2018–2019
Student Health Insurance Plan
Policy No. 2018K1A44
Effective 8/17/18–8/17/19

Swarthmore College
Swarthmore, PA

Underwritten by:

National Guardian Life Insurance Company (NGL), Madison, WI.
National Guardian Life Insurance Company is not affiliated with

Claims Administered by:

COMMERCIAL TRAVELERS LIFE INSURANCE COMPANY
70 Genesee Street
Utica, NY 13502
1.800.756.3702

Product underwritten by
National Guardian Life Insurance Company (NGL), Madison, WI.
National Guardian Life Insurance Company is not affiliated with

As Policy Form No.: NBH-280(2015)PPO PA Rev. 2018

2018-K1A44 Bro.
For a list of Cigna PPO Network Participating Providers, go to www.mycigna.com

AM I ELIGIBLE?

Swarthmore College is making available a Student Health Insurance program (hereinafter called “plan”) underwritten by National Guardian Life Insurance Company and administered by Commercial Travelers Life Insurance Company. This brochure provides a general summary of the insurance coverage. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy will be available for review upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

All registered students are required to have Health insurance and therefore are automatically enrolled in this Insurance Plan unless a waiver is completed. The charge for the annual premium will be included on the student's fall invoice. Those students who are insured under another policy may drop their coverage under this Insurance Plan and have the premium credited back to the student account by completing a waiver form by the June 15th deadline. For new incoming Spring students, the deadline to submit a waiver is February 17th.

The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.
Newly Born Children - A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. To continue coverage beyond this initial 31-day period, the Insured Person must:
1. Notify Us of the birth; and
2. Pay any additional premium.

HOW DO I WAIVE/ENROLL?

To Enroll:
1. Log into mySwarthmore < Click ‘Worth Health Center’ < Click ‘Student Health Portal’ < Click ‘Forms’
2. Complete the Annual Required Health Insurance information form

To Waive:
1. Log into mySwarthmore < Click ‘Worth Health Center’ < Click ‘Health Insurance Waiver’
2. Complete the Health Insurance Waiver form (enter your current health insurance policy information).

QUALIFYING LIFE EVENT

No changes of any type may be made during the plan year unless a qualified family or employment status change occurs. In all cases, the change in coverage must be consistent with the change in the person’s family or employment status. If you do have a qualifying change in status, you have 31 days from the event to make changes to your elections by completing a Qualifying Event Notification form and paying any applicable premium.

EFFECTIVE DATES AND COSTS

The Swarthmore College Student Health Insurance Plan provides coverage to students for a twelve (12) month period from 12:01 a.m. on August 17, 2018, through 12:01 a.m. on August 17, 2019.

<table>
<thead>
<tr>
<th></th>
<th>Annual* 8/17/18–8/17/19</th>
<th>Spring/Summer* 1/17/19–8/17/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,648</td>
<td>$956</td>
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<tr>
<td>Spouse</td>
<td>$1,648</td>
<td>$956</td>
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<tr>
<td>Child(ren)</td>
<td>$1,648</td>
<td>$956</td>
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*The above rates include an administrative fee

Effective Dates: Insurance under the 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, 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 health insurance plan; or
4. The Policy effective date.

TERMINATION OF BENEFITS

Termination Dates: An Insured Person’s insurance will terminate on the earliest of:
1. The date the 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 their 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.
REFUND OF PREMIUM

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 their 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, 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 their first semester; and
   b. Returns to their Home Country.

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

No other refunds will be allowed.

DEFINITIONS

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

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

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

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

Autism Spectrum Disorder means conditions that effect neurodevelopmental growth and defined as Pervasive Developmental Disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. This includes Aspergerger’s Syndrome.

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 Clinical Trials means phase I, II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:
  1. Involve the treatment of life-threatening medical conditions,
  2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives, and
  3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives.

Covered Clinical Trials must also meet the following requirements:
  1. Must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant
  2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.
  3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

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

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

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

Dependent means:
1. An Insured Student’s lawful spouse;
2. An Insured Student’s dependent biological or adopted child, child placed for adoption, foster or stepchild or a child covered due to a court or an administrative order, under age 26; and
3. An Insured Student’s unmarried biological or adopted child or stepchild 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 an 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, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. Elective Surgery includes, but is not limited to, circumcision, breast reduction, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

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

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

Essential Health Benefits means 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.

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 the Policy.

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

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

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

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

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

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

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

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

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

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

Non-Preferred Brand Drugs means drugs that have a higher copayment and have recently come on the market. In most cases, an alternative preferred medication is available. If a physician prescribes a brand-name drug when a generic equivalent is available, you must pay the difference in cost in addition to a copayment.

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

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, and loss of a body part.

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

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

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

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

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

School or College means the college or university attended by the insured student.

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.

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.

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of the individual from a facility.

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

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

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

PPO PLAN - PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have the Cigna PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of Cigna PPO Network of Participating Providers, go to www.mycigna.com.

Preferred Provider Organization

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

Note however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if:
1. There is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. There is an Emergency Medical Condition and the Insured Person cannot reasonably reach a network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.

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

You are responsible for notifying the claims administrator at the phone number found on Your ID card to begin the Pre-certification process. For inpatient benefits, the call must be made at least 3 working days before Hospital Confinement or surgery.

The following inpatient benefits require Pre-certification:

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

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

Pre-certification does not guarantee that Benefits will be paid. Your Physician will be notified of Our decision.

Failure by the claims administrator to make a determination within the time periods stated in the Policy will be deemed an Adverse Determination subject to an appeal.

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

SCHEDULE OF BENEFITS

Benefit Period: When an Insured Person receives initial medical treatment within 30 days of the occurrence of a Covered Injury or at the onset of a Covered Sickness, eligible benefits will be provided for a continuous Benefit Period. The Benefit Period begins: On the date of occurrence of such Covered Injury; or from the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of: the Policy Term (+ Extension of Benefits - when appropriate)

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

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

Deductible:
Network $0.00
Non-Network $100.00

Out-of-Pocket Expense Limit:
Network Provider: Individual $3,000
Non-Network Provider: Individual No maximum

Coinsurance Amount:
Network Provider: 90% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider: 80% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Network Providers and Non-Network Providers
The policy provides benefits based on the type of health care provider selected. The 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: Cigna

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.

<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
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<tbody>
<tr>
<td>Inpatient Benefits</td>
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<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
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<tr>
<td>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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<tr>
<td>Hospital Miscellaneous Expenses for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Physician’s Visits while Confined: Limited to one per day of Confinement</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
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<tr>
<td>Inpatient Surgery:</td>
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<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
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<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Registered Nurse Services</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense Benefit</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Mental Health Disorder</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
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<td><strong>Outpatient Benefits</strong></td>
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<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services &amp; supplies, such as cost of operating room, ambulatory surgery center, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood &amp; plasma</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
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<tr>
<td>Physical Therapy and Occupational therapy subject to combined limit of 30 visits per Policy Year</td>
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<tr>
<td>Speech Therapy limited to 30 visits per Policy Year</td>
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<tr>
<td>Habilitative Services are covered to the extent that they are Medically Necessary</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Emergency Services Expenses</td>
<td>90% of PPO Allowance</td>
<td>90% of PPO Allowance</td>
</tr>
<tr>
<td>In Office Physician’s Visits</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Laboratory Procedures (Outpatient)</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>90% of PPO Allowance for Prepayment</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Up to 60 visits per Policy Year</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Hospice Care Coverage</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Mental Health Disorder</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------</td>
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<tr>
<td><strong>Other Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental Care Benefit</td>
<td>See Benefit for limitations</td>
<td>See Benefit for limitations</td>
</tr>
<tr>
<td>Preventive Dental Care – limited to 1 dental exams every 6 months</td>
<td>100% of PPO Allowance</td>
<td>70% of Usual and Reasonable Charge for Preventive Services</td>
</tr>
<tr>
<td>Pediatric Vision Care Benefit</td>
<td>100% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Vision Care</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Routine Eye Exam once every 12 months</td>
<td></td>
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<tr>
<td>Chiropractic Care Benefit</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Subject to a maximum number of visits of 20 Policy Year</td>
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</tr>
<tr>
<td>Consultant/Specialist Physician Services</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td>Covered Clinical Trials</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Abortion Expense</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual and Reasonable</td>
</tr>
<tr>
<td><strong>Mandated Benefits</strong></td>
<td></td>
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<tr>
<td>Mastectomy and Reconstructive Surgery Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Treatment and Self-Management of Diabetes</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Mammography examinations</td>
<td>Same as any other Preventive Service</td>
<td></td>
</tr>
<tr>
<td>Cancer Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Dental Anesthesia for Children and Developmentally Disabled Insured Persons</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Medical Foods (Enteral Formulas) Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
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</tr>
</tbody>
</table>

**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 BENEFITS**

The Policy will coordinate benefits for expense covered by any other valid and collectible medical, health or accident insurance or pre-payment plan as stated in the Policy. Payments from such coverage from the plan will not be in excess of the total eligible expenses incurred.

**EXCLUSIONS AND LIMITATIONS**

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

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

1. **International Students Only** - expenses incurred within the Insured Person’s Home Country or country of regular domicile.
2. preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
3. routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
1. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.

2. Services provided by Student Health Fees.

3. Any expenses that are not recommended and approved by a Physician.

4. Expenses that are not covered under the policy and are not otherwise specifically covered under the policy.

5. Expenses that are not recommended and approved by a Physician.

6. Expenses that are not covered under the policy and are not otherwise specifically covered under the policy.

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37. Expenses that are not covered under the policy and are not otherwise specifically covered under the policy.
CLAIM PROCEDURES

In the event of an accident or sickness, the student should:
1. If on campus, report immediately to the Student Health Center so that proper treatment will be administered.
2. If off campus or the Student Health Center is closed, you may use an urgent care facility or consult a doctor and follow his/her instructions.

However, in the case of a medical emergency, go to the nearest hospital.

3. Mail to the address below all medical and hospital bills along with the patient’s name and insured student’s name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
4. File claim within ninety (90) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Submit all Claims to:
Cigna
P.O. Box 188061
Chattanooga, TN 37422-8061

CLAIMS APPEAL PROCESS

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include any additional information to support the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator at the address below.

Claims Administrator:
COMMERCIAL TRAVELERS
70 Genesee Street
Utica, NY 13502
800-756-3702

This plan is underwritten by:
National Guardian Life Insurance Company
As Policy Form No.: NBH-280(2015)PPO PA Rev. 2018

Servicing Agent:
Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
833-255-0743
www.gallagherstudent.com/swarthmore

For a copy of the privacy notice you may go to:
www.studentplanscenter.com/privacy/nglic

or

National Guardian Life Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502

or

Request one from the Health office at your school

(Please indicate what school you attend with your written request)

This is not the Policy. Rather, it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Policy, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state’s laws, including those relating to mandated benefits.

National Guardian Life Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. National Guardian Life Insurance Company will not deny or limit coverage to any health service based on the fact that an individual’s sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. National Guardian Life Insurance Company will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.
ON CALL INTERNATIONAL Global Assistance Program

The Global Assistance Program (GAP) is supplemental to the Student Insurance Plan. The GAP provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center at 1-855-226-7915 (toll free) or collect at 1-603-952-2045. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance.

The Global Assistance Program is effective when you are outside your home country, or over 100 miles from home within the United States or when you are traveling.

The following emergency services are included*:

Emergency Medical Evacuation and Repatriation If you suffer an accident, injury or sickness resulting in a serious medical condition which in the opinion of the On Call physician requires transportation to be treated adequately, On Call will arrange and pay for air and/or surface transportation, medical care during transportation, communication and all usual and customary ancillary charges incurred in moving and transporting you to the nearest hospital where appropriate medical care is available.

After being treated at a medical facility, On Call will arrange and pay for the transport of the Participant with a qualified medical attendant to the Country of Domicile or Country of Residence for further medical treatment or recovery should it be deemed medically necessary by the On Call physician.

Return of Remains In the event of death, On Call shall make the arrangements and pay for casket or air tray, preparation and transportation of their remains to their place of residence or to the place of burial.

Return of Dependent Children If your Dependent(s) are present but left unattended as a result of your hospitalization or Medical Evacuation, On Call shall make and pay for travel arrangements to return them home, including a non-medical escort as needed. This service has a limit of $5,000.

Visit by Family / Friend If the Participant has or will be hospitalized for more than five (5) days while traveling, On Call shall make and pay for travel arrangements and suitable hotel accommodations for a person of your choice to join them. This service includes flights and up to $200 a day for hotel for a maximum of seven (7) days, up to a combined service limit of $5,000.

*On Call International must pay and arrange for all services included above, reimbursement for self-paid expenses will not be considered; it is not insurance but it is added as a service in your Student Health Insurance Policy.

Additional Medical and Travel Assistance

If there are third party costs associated with the following services, On Call will notify you and you will be responsible for the costs: Pre-Trip Information; Referral to the nearest, most appropriate medical facility, and/or provider; Medical monitoring by board certified emergency physicians in the United States; Guarantee of Payment to provider and assistance in coordinating insurance benefits; Prescription Replacement Assistance or Dispatch of Medicine if not available locally; Emergency Message Forwarding to family, friends, personal physician, school etc; Emergency Travel Arrangements for disrupted travel; Legal Consultation and Referral; Interpreter Assistance and Referral; Lost Luggage Assistance; Lost/Stolen Travel Documents Assistance.

24 Hour Nurse Helpline

Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. A Registered Nurse counselor will provide a clinical assessment to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose Member’s ailments.

Contact On Call International to access any of the GAP services described above.

Toll Free from U.S. and Canada: 1-855-226-7915
Collect Worldwide: 1-603-952-2045
mail@oncallinternational.com

This is only an outline of services and terms, conditions and exclusions apply.

13
Gallagher Student Health & Special Risk Complements

Exclusively from Gallagher Student Health & Special Risk, the following menu of products are provided to all students currently enrolled in this Plan. For more information on all of the products & services listed below, visit your school’s page at www.gallagherstudent.com/swarthmore under the “Discounts and Wellness” tab.

EyeMed Vision Care
The discount vision plan is available through EyeMed Vision Care. EyeMed’s provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% and 45% off regular retail pricing. In addition, you can receive discounts off laser correction surgery at some of the nation’s most highly-qualified laser correction surgeons. You can take advantage of the savings immediately using your EyeMed ID card, which can be printed from the “Discounts and Wellness” tab on your school’s page at www.gallagherstudent.com/swarthmore.

Basix Dental Savings
Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services at reduced costs for students enrolled in a Gallagher Student Health & Special Risk Insurance Plan. It is important to understand the Dental Savings Program is not dental insurance. Basix contracts with dentists that agree to charge a negotiated fee to students covered under the Gallagher Student Health & Special Risk plan.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:
Find a contracted dentist from the Basix website.
Make an appointment with a contracted dentist- be sure to tell the dental office that you have access to the Basix Dental Savings program. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility.
Payment must be made at the time of service in order to receive the negotiated rate.
Full details of the program including lists of contracted dentists and fee schedules can found at www.basixstudent.com.

CampusFit
College health is all about helping students develop healthy habits for a lifetime. To support your efforts, CampusFit “digitizes” knowledge from registered dietitians and certified fitness instructors to help teach and reinforce mainstream ideas about diet, nutrition, fitness and general wellness.

The Energy Management section of the site allows a student to assess how much energy they are consuming, and expending on a daily basis and offers ways to improve food choices.
The Fitness Works section offers dozens of downloadable mp3 files and written exercise routines to help students get more active.
Want to run your first 5K? We’ve got a nine week, step-by-step plan to get you there.
The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce fundamental diet and nutrition ideas.