IMPORTANT NOTICE: This policy, and any forms accompanying it, is under review by the California Department of Insurance and has not been given final authorization for use in the State of California. Conditional authorization for use has been granted by the California Department of Insurance subject to changes required for compliance with California law. The information contained herein is subject to change subsequent to the Department’s regulatory review and shall be adjusted to the policy effective date based on final authorization.

Otis College of Art and Design ("the Policyholder")
2016-2017 Student Health Insurance Plan (SHIP) ("the Plan")

Insurance Underwritten by:
National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY ("the Company")

To download an ID card or for further information on this Plan, visit:
MFA Graphic Design students: https://consolidatedhealthplan.com/group/537/home
All other students: https://consolidatedhealthplan.com/group/523/home

Group Number:
S210116

Preventive Services

To download an ID card or for further information on this Plan, visit:
MFA Graphic Design students: https://consolidatedhealthplan.com/group/537/home
All other students: https://consolidatedhealthplan.com/group/523/home

Underwriter Reference No. CAS9151192
(Revision Date: 4-17)
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### ID CARD

If you are enrolled in the Plan, you may download your insurance ID card at the following links:

- MFA Graphic Design students: [https://consolidatedhealthplan.com/group/537/home](https://consolidatedhealthplan.com/group/537/home)
- All other students: [https://consolidatedhealthplan.com/group/523/home](https://consolidatedhealthplan.com/group/523/home)

If you go to a Doctor’s office, urgent care center, Hospital, or pharmacy, you will be asked for your ID card. **Carry your insurance identification card with you at all times.**

### NO-COST LANGUAGE ASSISTANCE SERVICES

(No Cost Language Assistance Services are not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

You are eligible to access the services of an interpreter to have insurance documents read to you in your native or preferred language, at no cost to you. To use this free service, call the number listed on your insurance ID card or **1 877 657 5030**. For further help, call the CA Department of Insurance at **1 800 927 4357**.

To download an insurance ID card or for further information on the Plan, visit:

- MFA Graphic Design students: [https://consolidatedhealthplan.com/group/537/home](https://consolidatedhealthplan.com/group/537/home)
- All other students: [https://consolidatedhealthplan.com/group/523/home](https://consolidatedhealthplan.com/group/523/home)
IMPORTANT CONTACT INFORMATION AND RESOURCES
FOR YOUR 2016-2017 STUDENT HEALTH INSURANCE PLAN ("the Plan")

Insurance underwritten by:
National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY ("the Company")

Group Number
S210116

Benefits Administrator
For questions regarding benefits or claims status, contact:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800 633 7867
www.chpstudent.com

Customer Services Representatives are available Monday - Friday 8:00 a.m. - 5:00 p.m. EST.

Claims Submission
For submitting claims by mail, send itemized bills and either a copy of your insurance ID card or completed claim form to:

Cigna
P.O. Box 188061
Chattanooga, TN 37422 8061
Electronic Payor ID:62308

Pre Certification for Hospitalization
Pre Certification is required for all inpatient hospitalization. Prior to scheduled hospitalization, or after an emergency admission, call:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800 633 7867
www.chpstudent.com

PPO Network
To find out if a Provider is a Cigna PPO Network Participating Provider visit www.cigna.com

Prescription Drugs
To find out if a pharmacy is a Cigna participating pharmacy:

• Call 1 800 633 7867; or
• Visit Cigna’s website at www.cigna.com or www.chpstudent.com

Plan Administrator
For questions regarding eligibility, or waivers, contact:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800 633 7867
www.chpstudent.com
ELIGIBILITY

Students
All registered students at Otis College of Art and Design are eligible for coverage under the Otis College of Art and Design Student Health Insurance Plan ("the Plan").

An eligible student must actively attend classes at Otis College of Art and Design for at least the first 30 days of the period for which he or she is enrolled. Except in the case of withdrawal from school due to Sickness or Injury, any student withdrawing from school during the first 30 days of the period for which he or she is enrolled will not be covered under the Plan, and a full refund of premium will be made less any claims paid. Students who withdraw after such 30 days will remain covered under the Plan and no refund will be made.

Eligibility requirements must be met each time premium is paid to continue coverage under the Plan. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

Dependents
Covered Students may also enroll their eligible Dependents in the Plan (see page 15 for Dependent definition). For all newly acquired Dependents (Spouse or Registered Domestic Partner and/or children), enrollment and full premium payment must be submitted within 31 days of the attainment of such Dependents (proof of date of birth, adoption, or marriage may be requested). For questions about enrollment, contact Consolidated Health Plans at 1 800 633 7867.

ENROLLMENT

Students
International students are required to have coverage under the Plan and will be automatically enrolled at registration and the cost for the coverage will be included in the student's fees.

Domestic students registered for and attending classes are eligible and will be automatically enrolled in the Plan at registration and the cost for the coverage will be included in the student's fees unless a waiver of coverage is completed and proof of alternate comparable health insurance coverage is submitted to Consolidated Health Plans during the student's first term of attendance and approved by the Waiver Deadline Date shown below.

A domestic student who initially waived coverage under the Plan but subsequently experiences Involuntary Loss of Coverage may elect to enroll for coverage under the Plan within 31 days of the date of Involuntary Loss of Coverage.

Dependents
Eligible students who are enrolled in the Plan may also enroll their eligible Dependents (see definition of Dependent) by the Enrollment Deadline Date listed on page 6. Dependents can be enrolled online at:

MFA Graphic Design students: https://consolidatedhealthplan.com/group/537/home
All other students: https://consolidatedhealthplan.com/group/523/home.

Dependents must be enrolled in the same term in which the Covered Student is enrolled.

An eligible student may enroll for coverage for his or her Dependent by the Enrollment Deadline Date or within 31 days of: marriage, birth, adoption or placement for adoption, arrival in the U.S., or ineligibility under another creditable coverage plan (proof of date of arrival in the U.S., birth, adoption, or marriage may be requested). Newly acquired Dependents (Spouse or Registered Domestic Partner and/or children) are not subject to the Enrollment Deadline Dates. However, enrollment and full payment of insurance cost for all newly acquired Dependents (Spouse or Registered Domestic Partner and/or children) must be submitted within 31 days of marriage, birth, adoption or placement for adoption, or arrival in the U.S. (proof of date of arrival in the U.S., birth, adoption, or marriage may be requested). Otherwise, enrollment cannot be accepted after the Enrollment Deadline Dates listed (see page 6).

For questions about Dependent enrollment, contact Consolidated Health Plans at 1 800 633 7867.

WAIVING COVERAGE UNDER THE PLAN (DOMESTIC STUDENTS)

A domestic student who is registered and attending classes at the College is eligible and will be automatically enrolled in and charged the cost for the Plan unless a waiver is completed and proof of alternate comparable health insurance coverage is submitted to Consolidated Health Plans by the Waiver Deadline Date during their first term of attendance.

Domestic students can waive coverage under the Plan by visiting the links shown below and clicking on the waiver link, then following the prompts to submit a waiver application by the waiver deadline date:

MFA Graphic Design students: https://consolidatedhealthplan.com/group/537/home
All other students: https://consolidatedhealthplan.com/group/523/home
WAIVING COVERAGE UNDER THE PLAN (DOMESTIC STUDENTS) (Continued)

Domestic students who do not submit a waiver application, along with proof of alternate comparable health insurance coverage by the Waiver Deadline Date during their first term of attendance for the Policy Year, will be automatically enrolled in the Plan, and the cost for the coverage will be included in the student's fees. **Alternate coverage will be verified.** Comparable coverage must meet all of the following requirements:

- Coverage must be continuous (no break or termination) for the entire academic year;
- Maximum benefit must be unlimited; and
- Company must be operated and claims paid in the United States, and in full compliance with U.S. insurance laws.

Students who are covered under a health insurance plan that does not meet the applicable requirements will not be allowed to waive coverage under the Plan. For additional questions regarding the waiver procedure, please contact Consolidated Health Plans at 1 800 633 7867.

### Waiver Deadline Dates

<table>
<thead>
<tr>
<th>MFA Graphic Design Students</th>
<th>All Other Domestic Registered Students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Term of Coverage</strong></td>
<td><strong>Waiver Open Date</strong></td>
</tr>
<tr>
<td>Fall</td>
<td>05/06/16</td>
</tr>
<tr>
<td>Spring</td>
<td>11/13/16</td>
</tr>
<tr>
<td>Fall</td>
<td>05/6/16</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>11/13/16</td>
</tr>
</tbody>
</table>

### TERMS OF COVERAGE

**Effective Date of Coverage**

The Policy is effective at 12:01 a.m. on August 19, 2016.

The coverage of an eligible student, including the student who initially waived coverage and subsequently enrolls within 31 days of the date of Involuntary Loss of Coverage, shall take effect at 12:01 a.m. on the latest of the following dates: 1) the Policy Effective Date; 2) the day after the date for which the first premium for the Covered Student’s coverage is received by the Company; 3) the date the College’s term of coverage begins; or 4) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the College.

Coverage for an international student will begin at 12:01 a.m. on the date the Covered Student departs his or her home country, or country of regular domicile, if: 1) the Covered Person is traveling directly to the College sponsored program; and 2) such travel commences within 72 hours of the effective date of coverage for the then current term for which premium has been paid; and 3) travel is directly from the country of regular domicile to the campus; and 4) such travel is not longer than 48 hours in length.

**Dependents**

A covered Dependent’s coverage shall take effect at 12:01 a.m. on the later of the following dates: 1) the date the coverage for the Covered Student becomes effective; or 2) the date the Dependent is enrolled for coverage, provided premium is paid when due. If enrollment for coverage is made more than 31 days following the date the Dependent becomes eligible, then his or her insurance will become effective only if and when the Company gives its written consent.

**Termination Date of Coverage**

The Policy terminates at 11:59 p.m. on August 18, 2017 (See specific termination dates for Academic Divisions below).

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:

1. The date the Policy terminates;
2. The last day for which any required premium has been paid; or
3. The date on which the Covered Student withdraws from the school:
   a) because of entering the armed forces of any country (premiums will be refunded on a pro rata basis, less any claims paid, when written request is made within 90 days of leaving school); or
   b) when the withdrawal from school is during the first 30 days of the period for which the student is enrolled and is for a reason other than withdrawal from school due to Sickness or Injury (a full refund of premium will be made, less any claims paid, when written request is made within 90 days of leaving school); or
   c) because of departure from the Policyholder’s school for his or her home country (premiums will be refunded on a pro rata basis, less any claims paid, only upon written proof from the Policyholder that the Covered Student is no longer an eligible person).
TERMS OF COVERAGE (Continued)

If withdrawal from the Policyholder’s school is for other than a), b), or c) above, no premium refund will be made. Covered Students, including those who withdraw from the Policyholder’s school during the first 30 days due to Injury or Sickness, will be covered for the Policy term for which they are enrolled and for which premium has been paid.

Except as specifically provided in the Policy, Dependent coverage will not be effective prior to that of the Covered Student or extend beyond that of the Covered Student.

INSURANCE COSTS* AND DATES OF COVERAGE

<table>
<thead>
<tr>
<th>MFA Graphic Design Students</th>
<th>Fall 8/19/16 to 01/16/17</th>
<th>Spring 01/17/17 to 06/18/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term of Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Enrollment Deadline Date</td>
<td>Please contact Consolidated Health Plans at 800 633 7867</td>
<td>02/13/17</td>
</tr>
<tr>
<td>Student</td>
<td>$850</td>
<td>$850</td>
</tr>
<tr>
<td>Spouse/Registered Domestic Partner</td>
<td>$850</td>
<td>$850</td>
</tr>
<tr>
<td>One Child</td>
<td>$850</td>
<td>$850</td>
</tr>
<tr>
<td>Two Children</td>
<td>$1,700</td>
<td>$1,700</td>
</tr>
<tr>
<td>Three or more Children***</td>
<td>$2,550</td>
<td>$2,550</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Other Registered Domestic Students</th>
<th>Fall 08/19/16** to 01/16/17</th>
<th>Spring/Summer 01/17/17 to 08/18/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term of Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Enrollment Deadline Date</td>
<td>09/18/16</td>
<td>02/13/17</td>
</tr>
<tr>
<td>Student</td>
<td>$850</td>
<td>$1,170</td>
</tr>
<tr>
<td>Spouse/Registered Domestic Partner</td>
<td>$850</td>
<td>$1,170</td>
</tr>
<tr>
<td>One Child</td>
<td>$850</td>
<td>$1,170</td>
</tr>
<tr>
<td>Two Children</td>
<td>$1,700</td>
<td>$2,340</td>
</tr>
<tr>
<td>Three or more Children***</td>
<td>$2,550</td>
<td>$3,510</td>
</tr>
</tbody>
</table>

*The cost of coverage includes administrative fees.
**August 25, 2016 for students maintaining continuous coverage from the prior Policy Year.
***Premium is charged per child, up to 3 times the premium fee, after which no further premium is charged for additional children.

Please note that Dependents must renew their coverage within 31 days of the termination date of their last term of coverage in order to maintain continuous coverage, regardless of the Enrollment Deadline Date. There is no continuation coverage for the Plan for students and/or Dependents who are no longer eligible.

Eligibility requirements must be met each time premium is paid to continue coverage.

REFUND POLICY

Refund of premium will be made only if the Covered Student withdraws from the College:

1. Because of entering the armed forces of any country (premiums will be refunded on a pro rata basis, less any claims paid, when written request is made within 90 days of leaving school).
2. When the withdrawal from the College is during the first 30 days of the period for which the student is enrolled and is for a reason other than withdrawal from school due to Sickness or Injury (a full refund of premium will be made, less any claims paid, when written request is made within 90 days of leaving school).
3. Because of departure from the College for his or her home country (premiums will be refunded on a pro rata basis, less any claims paid, only upon written proof from the College that the Covered Student is no longer an eligible person).

If withdrawal from the College is for other than 1), 2), or 3) above, no premium refund will be made. Covered Students, including those who withdraw from the College during the first 30 days due to Injury or Sickness, will be covered for the Policy term for which they are enrolled and for which premium has been paid.
IN VOLUNTARY LOSS OF COVERAGE

A domestic student who, initially waived coverage under the Plan but subsequently experiences Involuntary Loss of Coverage may elect to enroll for coverage under the Plan within 31 days of the date of Involuntary Loss of Coverage. Please contact Consolidated Health Plans at 1 800 633 7867 for assistance in enrollment.

Involuntary Loss of Coverage means that prior coverage has been involuntarily terminated due to no fault of the Covered Student. Such includes coverage that terminates due to loss of employment by Spouse or Registered Domestic Partner or parent. It does not include coverage that has a predetermined termination date; expiration of COBRA eligibility; or coverage that has been voluntarily terminated. Please note: Premium payments cannot be prorated. Students must pay the entire premium for the term in which they are electing to enroll. Coverage will become effective the day after the date the Company receives payment.

Domestic students who have waived enrollment in the Plan and later wish to enroll in the school insurance Plan, but who have not had an Involuntary Loss of Coverage, may elect to enroll in the next ensuing term of coverage, provided they maintain eligibility status.

EXTENSION OF BENEFITS

If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the earliest of: 1) the date the Hospital Confinement ends; or 2) the end of the 90 day period following the date his or her coverage terminated.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Plan or any other health insurance policy in the ensuing term of coverage.

PREFERRED PROVIDER ORGANIZATION

Please note that the PPO network for the Plan is Cigna Network.

Please read the following information so you will know from whom or what group of providers health care may be obtained.

The Plan has incorporated into the coverage access to the Cigna Network of Hospitals and Doctors (PPO), which is the Preferred Provider Organization for the Plan. A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. Coverage is available nationwide for Eligible Expenses incurred at 80% of Allowable Charges when treated by network providers (PPO) and 50% of Reasonable and Customary (R&C) charges when treated by non network providers (Non PPO). However, if such treatment is received by a Non PPO provider or facility because of an Emergency Medical Condition, benefits for Eligible Expenses are payable at the PPO level. For a complete listing of PPO Hospitals and Doctors, visit www.cigna.com.

If a Covered Person is being treated by a PPO Provider for an acute, serious chronic condition, pregnancy, newborn, or a terminal illness and the Provider’s contract terminates with the PPO, the Covered Person may be eligible under certain conditions to continue treatment with the Provider at the PPO rate. Contact the claims administrator, listed on page 3, for details.

If a Covered Person is referred by a PPO provider to another facility, it does not mean that the provider or facility to which he/she is referred is also a PPO provider. For instance, when a network provider refers a Covered Person to a lab for tests, he/she should be sure it is a network lab.

PRE-CERTIFICATION FOR HOSPITALIZATION

The Covered Person is responsible to fulfill the Pre Certification requirement of the Plan. ALL INPATIENT STAYS MUST BE CERTIFIED BY THE UTILIZATION REVIEW ORGANIZATION (CIGNA).

The following inpatient services require Pre Certification by Cigna:

1. For other than a Mastectomy or lymph node dissection, all inpatient admissions, including length of stay, to a Hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, a residential treatment facility; and
2. For all partial hospitalization in a Hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

Pre Certification of Non Emergency Hospitalizations: The patient, Doctor or Hospital must telephone Consolidated Health Plans at 1 800 633 7867 at least 5 days prior to the planned admission. Cigna shall approve, modify or deny the Pre Certification within 5 business days of receipt.

Notification of Emergency Admissions: The patient, patient’s representative, Doctor or Hospital must telephone Consolidated Health Plans at 1 800 633 7867 within 2 days of admission. Cigna shall approve, modify or deny the Notification of Emergency Admissions within 72 hours of receipt.
PRE CERTIFICATION FOR HOSPITALIZATION (Continued)

All Hospital Admissions will be monitored by Cigna. Each admission is reviewed to determine the appropriate length of stay and to establish a treatment plan.

If the Covered Person does not secure Pre Certification for covered non Emergency admissions or provide notification of covered emergency admissions, his/her Eligible Expenses will be subject to an additional $750 per admission penalty not to exceed the Eligible Expenses payable.

Pre Certification is not a guarantee that benefits will be paid.

● OUT-OF-POCKET LIMIT

The Out of Pocket Limit is the maximum amount a Covered Person will pay for Eligible Expenses incurred during a Policy Year. The Out of Pocket Limit includes Deductibles, Co-payments and Coinsurance. The Out of Pocket Limit does not include charges in excess of Reasonable and Customary; charges in excess of any specified maximum; or charges incurred for any services not covered under the Policy.

When the Out of Pocket Limit becomes applicable to a Covered Person during a Policy Year, Covered Percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person in the remainder of that Policy Year up to any benefit maximum that may apply.

If, in any Policy Year, the sum of Eligible Expense used toward the Out of Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out of Pocket Limit, the Out of Pocket Limit will be deemed to be met with respect to Eligible Expense incurred by such Covered Student and his or her covered Dependents for the rest of that Policy Year. When the Family Out of Pocket Limit is reached, the Covered Percentage will be increased to 100% of the Eligible Expenses incurred for the remainder of that year.

● SCHEDULE OF BENEFITS

This Plan would satisfy the GOLD Level - Actuarial Value 81.92%

The Company will pay for the Eligible Expenses listed below, up to the following limits:

<table>
<thead>
<tr>
<th>Aggregate Maximum Benefit:</th>
<th>PPO</th>
<th>NON PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Amount per Policy Year:</td>
<td>$250 per Covered Person ($500 per family)</td>
<td>$750 per Covered Person ($1,500 per family)</td>
</tr>
<tr>
<td>Office Visit and Urgent Care Co pay:</td>
<td>$20 per visit</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Emergency Room Co pay:</td>
<td>$150 per visit (waived only if the Covered Person is admitted to Hospital as an inpatient)</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Limit per Policy Year:</td>
<td>$5,900 per Covered Person ($11,800 per family)</td>
<td>$12,700 per Covered Person ($25,400 per family)</td>
</tr>
</tbody>
</table>

The Covered Person is responsible for paying the Deductible amount listed before the Company will begin paying benefits, except as indicated below. Eligible Expenses include the following, subject to the limitations indicated above or below:

<table>
<thead>
<tr>
<th>PREVENTIVE SERVICES</th>
<th>PPO</th>
<th>NON PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services includes screening for certain conditions such as: cancer, high cholesterol, depression, diabetes, obesity, and sexually transmitted diseases, and women's preventive care; as recommended by the U.S. Department of Health and Human Services</td>
<td>PPO Providers or Student Health and Wellness Center; 100% of Allowable Charges NOT SUBJECT TO DEDUCTIBLE OR CO‐PAYS</td>
<td>Paid as any other covered condition</td>
</tr>
<tr>
<td>Immunizations includes but not limited to: flu shot, tetanus, diphtheria, pertussis, Tdap, hepatitis A, hepatitis B, HPV, measles mumps rubella, pneumonia, varicella, meningococcal; as recommended by the U.S. Centers for Disease Control and Prevention</td>
<td>100% of Allowable Charges NOT SUBJECT TO DEDUCTIBLE OR CO‐PAYS</td>
<td>Paid as any other covered condition</td>
</tr>
<tr>
<td>Contraceptives FDA approved contraceptive methods and medications, as prescribed by a Doctor</td>
<td>100% of Allowable Charges NOT SUBJECT TO DEDUCTIBLE OR CO‐PAYS</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Please visit [www.hhs.gov/healthcare/prevention](http://www.hhs.gov/healthcare/prevention) for more details on what preventive services are included under the Patient Protection and Affordable Care Act.
### INPATIENT

<table>
<thead>
<tr>
<th>Description</th>
<th>PPO</th>
<th>NON PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Expense (Daily Room and Board and Hospital Miscellaneous)</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of Reasonable &amp; Customary (&quot;R&amp;C&quot;)</td>
</tr>
<tr>
<td>daily room and board limited to average semi private rate, except when a private room is Medically Necessary, or if intensive care unit, coronary care unit, or isolation unit; miscellaneous Hospital expenses, such as expenses incurred for anesthesia and operating room; laboratory tests and X rays (including professional fees); oxygen tent; drugs, medicines (excluding take home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity and Newborn Care</strong></td>
<td>80% of Allowable Charges</td>
<td>Paid as any other covered condition</td>
</tr>
<tr>
<td>while Hospital Confined, and routine nursery care provided immediately after birth, for no less than 48 hours after birth (96 hours for cesarean delivery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), provided such care is: a) rendered during Hospital Confinement; b) Medically Necessary; and c) no other charge is made for such service</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Expense</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>When Injury or Sickness requires two or more surgical procedures which are performed through the same incision, and at the same time or immediate succession, the Company will pay the applicable covered percentage of the first procedure and 50% of the value for the second procedure performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Anesthetist</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>professional services in connection with inpatient surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy/ Occupational Therapy/ Speech Therapy</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Inpatient Doctor’s Fees Expense</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Pre Admission Testing</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Mental Health Services Expense</strong></td>
<td>Paid as any other covered condition</td>
<td></td>
</tr>
<tr>
<td><strong>Alcoholism or Substance Abuse Expense</strong></td>
<td>Paid as any other covered condition</td>
<td></td>
</tr>
</tbody>
</table>

### OUTPATIENT

<table>
<thead>
<tr>
<th>Description</th>
<th>PPO</th>
<th>NON PPO*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor Fees Expense</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td>Benefits include infusion therapy and allergy shots when administered in the Doctor’s office. Routine physical examinations including preventive vision screening and hearing exams, health education counseling and programs for tobacco cessation and stress management will be payable at 100% and are not subject to the Co pay or Deductible Amount when rendered by a PPO Provider only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor (other than Specialist)</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td>When the services are rendered at the Student Health and Wellness Center, the benefit will be payable at 100% of the Allowable Charge after a Co pay Amount of $20 per visit and are not subject to the Deductible Amount. This includes immunizations and/or injections administered by the Student Health and Wellness Center Doctor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Hospital Emergency Room and Non Scheduled Surgery</strong></td>
<td>80% of Allowable Charges</td>
<td>80% of R&amp;C after $150 Co pay per visit</td>
</tr>
<tr>
<td>for use of Hospital Emergency Room, including operating room, laboratory, X-ray examinations, and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td><strong>PPO</strong></td>
<td><strong>NON PPO</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Urgent Care Expense</strong>&lt;br&gt;always use urgent care facilities instead of a Hospital emergency room, when possible</td>
<td>80% of Allowable Charges after $20 Co pay per visit (not subject to Deductible)</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Second Medical or Surgical Opinion Expense</strong></td>
<td>80% of Allowable Charges after $20 Co pay per visit</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Surgical Expense</strong>&lt;br&gt;When Injury or Sickness requires two or more surgical procedures which are performed through the same incision, and at the same time or immediate succession, the Company will pay the applicable covered percentage of the first procedure and 50% of the value for the second procedure performed.</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Anesthetist</strong>&lt;br&gt;professional services in connection with outpatient surgery</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Day Surgery Facility/ Miscellaneous</strong>&lt;br&gt;When scheduled surgery is performed in a Hospital/outpatient facility/ambulatory surgical center, including: use of the operating room; laboratory tests and x ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines).</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Rehabilitative Care Services/Habilitative Services</strong>&lt;br&gt;(Physiotherapy, occupational therapy, chiropractic care, cardiac/pulmonary)</td>
<td>80% of Allowable Charges after $20 Co pay per visit</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Speech and Hearing Therapy</strong></td>
<td>80% of Allowable Charges after $20 Co pay per visit</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Mental Health Services Expense</strong></td>
<td>Paid as any other covered condition</td>
<td>Paid as any other covered condition</td>
</tr>
<tr>
<td><strong>Alcoholism or Substance Abuse Expense</strong></td>
<td>Paid as any other covered condition</td>
<td>Paid as any other covered condition</td>
</tr>
<tr>
<td><strong>Allergy Testing</strong>&lt;br&gt;Benefits include, but are not limited to, charges for the following: laboratory tests; Doctor’s office visits; prescribed medications for testing of the allergy including equipment used in the administration of prescribed medication; and other Medically Necessary supplies and services.</td>
<td>Paid as any other covered condition</td>
<td>Paid as any other covered condition</td>
</tr>
<tr>
<td><strong>X Ray and Laboratory Services</strong>&lt;br&gt;(not otherwise covered under Preventive Services)&lt;br&gt;Includes benefits for a mammography for screening or diagnostic purposes when requested by the attending Doctor. Benefits paid at 100% of Allowable Charge, not subject to Deductible, when services are rendered at the Student Health and Wellness Center</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>CAT Scan/MRI/PET Scan</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Radiation Therapy and Chemotherapy</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>80% of Allowable Charges after $20 Co pay per visit</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Dialysis and Filtration Procedures</strong></td>
<td>80% of Allowable Charges after $20 Co pay per visit</td>
<td>50% of R&amp;C after $30 Co pay per visit</td>
</tr>
<tr>
<td><strong>Diagnostic Services and Medical Procedures</strong>&lt;br&gt;performed by a Doctor (other than Doctor’s visits, Physiotherapy, X rays, and lab procedures) (not otherwise covered under Preventive Services)</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>OTHER</td>
<td>PPO</td>
<td>NON PPO*</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Ambulance Expense*</td>
<td>80% of R&amp;C</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment*/Orthopedic Braces and Appliances</td>
<td>80% of Allowable Charges</td>
<td>80% of R&amp;C</td>
</tr>
</tbody>
</table>
*The Company will determine whether to rent or purchase such equipment. Benefit paid at 100% of Allowable Charge, not subject to the deductible, when obtained at the Student Health and Wellness Center.

| Prosthetic Appliances and Devices                        | 80% of Allowable Charges | 80% of R&C                |
Benefits include charges for prescribed internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a covered surgery.

| Consultant’s Fees Expense                               | 80% of Allowable Charges | 50% of R&C                |

| Dental Treatment Expense for Injury to Natural Teeth only | 80% of Actual Charge     | 80% of Actual Charge       |

| Pediatric Dental Treatment Expense (for Covered Persons under age 19 only) | $20 Co pay per visit, then Eligible Expenses paid at: | 
| Diagnostic & Preventive Services: 100% of Actual Charge | 100% of R&C up to $225; 50% thereafter |
| Basic Services: 50% of Actual Charge | 100% of R&C up to $225; 50% thereafter |
| Primary/Major Services: 50% of Actual Charge | Primary/Major Services: 50% of Actual Charge |
| Orthodontic Services: 50% of Actual Charge | Orthodontic Services: 50% of Actual Charge |

| Pediatric Vision Care Expense (for Covered Persons under age 19 only) | 100% of R&C up to $225; 50% thereafter | 100% of R&C up to $225; 50% thereafter |
Co pay per visit:
| Examination (including low vision testing) | $20 | $20 |
| Materials | 100% of R&C | 100% of R&C |
Covered Percentage:
| Examination (including low vision testing) | 100% of R&C | 100% of R&C |
| Materials (other than optional lenses and treatments) | 50% of R&C | 50% of R&C |
Includes:
- Standard Lenses (glass, plastic or polycarbonate) (single vision, bifocal, trifocal, lenticular, progressive):
- Frames:
- Contact Lenses (in lieu of eyeglass lenses and frames) Fit, Follow up & Materials: Effective Medically Necessary
- Optional Lenses and Treatments, including: Plastic Photosensitive lenses (Transitions), Blended Segment Lenses, Intermediate Vision Lenses, Premium Progressive Lenses (Varilux, etc.), Select and Ultra Progressive Lenses, Photochromic Glass Lenses, Polarized Lenses, Anti-Reflective Coating (Standard/Premium/Ultra), High-Index Lenses.
- Low Vision Therapy
- Low Vision Aids -

| Special Contact Lenses (for Covered Persons age 19 and older) | 75% of R&C up to $500; 50% thereafter | 75% of R&C up to $500; 50% thereafter |
| Includes benefit for special contact lenses for aniridia when prescribed by an optometrist or other Doctor. Up to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any Policy Year to treat aniridia (missing iris). Special contact lenses for a Covered Person under age 19 will be paid under the Pediatric Vision Care Expense (please see the Policy on file with the Policyholder for full details). | $20 Co pay per visit, then Eligible Expenses paid at: | 60% of R&C |

| Vision Care Expense (for Covered Persons age 19 and over) Co pay per visit: | 100% of R&C | 60% of R&C |
Co pay per visit:
| Examination | $20 | $20 |
| Materials | 100% of R&C | 60% of R&C |
Covered Percentage:
| Examination | $20 | $20 |
| Materials | 100% of R&C | 60% of R&C |
Includes:
- Standard Plastic Lenses (single vision, bifocal, trifocal, lenticular, progressive)
- Frames
- Contact Lenses (in lieu of eyeglass lenses and frames) Fit, Follow up & Materials: Effective Medically Necessary
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>PPO</th>
<th>NON PPO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services for Radiation Treatment</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C after $20 Co pay per visit</td>
</tr>
<tr>
<td>Includes benefits for dental evaluation, X rays, fluoride treatment, and extractions necessary to prepare the Covered Person’s jaw for radiation therapy of cancer in his or her head or neck.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Paid as any other covered condition</td>
<td></td>
</tr>
<tr>
<td>including Complications of Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning Services (not otherwise covered under Preventive Services), includes Vasectomy and Elective Abortion</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Acupuncture Expense</td>
<td>Paid as any other covered condition</td>
<td></td>
</tr>
<tr>
<td>Diagnosis and Treatment of Sleep Disorders</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>after $20 Co pay per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous Home Therapy</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care Expense</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Hospice Care Expense</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Organ and Tissue Transplant Expense</td>
<td>Paid as any other covered condition</td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery Expense</td>
<td>Paid as any other covered condition</td>
<td></td>
</tr>
<tr>
<td>Prenatal Diagnosis of Genetic Disorders Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRESERVED MEDICINES EXPENSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIGNA PARTICIPATING PHARMACIES ONLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This benefit is not subject to the Policy Year Deductible. Eligible Expenses include all FDA approved smoking cessation medication including over-the-counter drugs for which there is a written order; and drugs prescribed by a Doctor. This benefit applies to all prescribed FDA approved contraceptive drugs and devices, including over-the-counter contraceptives. The Co pay and Covered Percentage do not apply to prescribed FDA approved birth control when obtained from a participating pharmacy only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Health and Wellness Center</td>
<td>100% of Actual Charge after Co pay per prescription:</td>
<td></td>
</tr>
<tr>
<td>Limited to 30 day supply per prescription or refill</td>
<td>Generic Drugs (Tier 1): $0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs (Tier 2): $20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Preferred Brand Drugs (Tier 3): $70</td>
<td></td>
</tr>
<tr>
<td>Retail Participating Pharmacies</td>
<td>100% of Actual Charge after Co pay per prescription:</td>
<td>Not covered</td>
</tr>
<tr>
<td>Co pay applies to each 30 day supply. Limited to 30 day supply per prescription or refill. For Cigna Pharmacy locations visit <a href="http://www.cigna.com">www.cigna.com</a></td>
<td>Generic Drugs (Tier 1): $20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs (Tier 2): $30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand Drugs (Tier 3): $70</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs (Some generic drugs, preferred brand drugs and non-preferred brand drugs are considered to be specialty medications.) Co pay applies to each 30 day supply. Limited to 30 day supply per prescription or refill. For more information, contact Cigna PBM at 1 800 325 1404</td>
<td>100% of Actual Charge after Co pay per prescription:</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs: $200</td>
<td></td>
</tr>
<tr>
<td>Mail Order</td>
<td>100% of Actual Charge after Co pay per prescription:</td>
<td>Not covered</td>
</tr>
<tr>
<td>Co pay applies to each 90 day supply. Limited to a 90 day supply per prescription or refill. For more information go to <a href="http://www.cigna.com">www.cigna.com</a></td>
<td>Generic Drugs (Tier 1): $40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs (Tier 2): $60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Preferred Brand Drugs (tier 3): $140</td>
<td></td>
</tr>
</tbody>
</table>

Emergency Services treatment or care rendered by a non PPO provider is mandated by the Patient Protection and Affordable Care Act to be provided at the same benefit and cost sharing level as services provided by PPO provider.

ACCIDENTAL DEATH AND DISMEMBERMENT
The Company will pay the benefit below for Injuries to a Covered Person: 1) caused by an Accident which happens while covered by the Plan; and 2) which results in any of the losses listed below within 180 days of the Accident that caused the Injury.

<table>
<thead>
<tr>
<th>For Loss of</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$10,000</td>
</tr>
<tr>
<td>Both Hands or Both Feet or Sight of Both Eyes</td>
<td>$10,000</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>$10,000</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>$10,000</td>
</tr>
<tr>
<td>One Foot and Sight of One Eye</td>
<td>$10,000</td>
</tr>
<tr>
<td>One Hand or One Foot or Sight of One Eye</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means the total, irrevocable loss of the entire sight in that eye. "Severance" means the complete separation and dismemberment of the part from the body.
ACCIDENTAL DEATH AND DISMEMBERMENT (Continued)
If a Covered Person suffers more than one Loss as a result of the same Accident, the Company will pay only for the Loss with the largest benefit.

The exclusions below are in addition to the General Exclusions. No Accidental Death and Dismemberment benefits will be payable for any Loss caused by:

1. Sickness, disease, mental incapacity, or bodily infirmity;
2. Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning, or an accidental cut or wound independent and in the absence of an underlying Sickness, disease, or condition;
3. Medical or surgical treatment, except for a Loss that results directly from a surgical operation made necessary by an Injury which is the result of an Accident and is performed within three (3) months of the Accident; or
4. Covered Person being intoxicated or under the influence of any controlled substance unless administered on the advice of a Doctor.

In addition to the above, this provision is subject to the General Exclusions as provided in the Policy.

EMERGENCY MEDICAL EVACUATION
MAXIMUM AMOUNT $50,000
The Company will pay, subject to the limitations set out in the Policy on file with the Policyholder, for eligible emergency medical evacuation expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her emergency medical evacuation but not exceeding $50,000 per Covered Person for all emergency medical evacuations due to all Injuries from the same Accident or all emergency Sicknesses from the same or related causes. The Doctor ordering the emergency medical evacuation must certify that the severity of the Covered Person's Injury or emergency Sickness warrants his or her emergency medical evacuation. All Transportation arrangements made for the emergency medical evacuation must be by the most direct and economical conveyance and route possible. Travel Guard must make all arrangements and must authorize all expenses in advance for any emergency medical evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance.

(Please see page 19 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.)

REPATRIATION OF REMAINS
MAXIMUM AMOUNT $50,000
If a Covered Person suffers loss of life due to Injury or emergency Sickness, the Company will pay, subject to the limitations set out in the Policy on file with the Policyholder, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to $50,000 per Covered Person. Eligible Expenses include, but are not limited to: 1) embalming or cremation; 2) the most economical coffins or receptacles adequate for transportation of the remains; and 3) transportation of the remains by the most direct and economical conveyance and route possible. Travel Guard must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance.

(Please see page 19 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.)

STATE MANDATED BENEFITS
The State of California mandates coverage for certain benefits which are covered by the Plan of insurance, including the following:

1) equipment, supplies, and outpatient self management training for diabetes; 2) phenylketonuria (PKU), including enteral formulas and special food products that are part of a diet prescribed by a Doctor; 3) treatment of Severe Mental Illness and serious emotional disturbance of a child; 4) anesthesiain and facility charges for dental procedures under certain circumstances; 5) preventive care for children aged 18 and under, according to the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; 6) behavioral health treatment for pervasive developmental disorder or autism; 7) mammograms; 8) prostate, colorectal, and cervical cancer screening and generally medically accepted cancer screening tests; 9) breast cancer screening, diagnosis, and treatment; 10) a second opinion requested by a Covered Person or Doctor; 11) participation in the California Prenatal Screening Program; 12) prosthetic devices to restore a method of speaking incidental to laryngectomy; 13) diagnosis, treatment, and management of osteoporosis; 14) clinical trials; 15) AIDS vaccine; 16) reconstructive surgery under certain circumstances; 17) telemedicine medical services/telehealth services; 18) treatment of conditions relating to diethylstilbestrol exposure; 19) Medically Necessary surgical treatment for jaw bone conditions (TMJ); 20) screening for blood lead levels in children; 21) maternity services as provided by CA Insurance Code section 10123.87 (a); 22) nicotine treatment; 23) off label prescription drug use; 24) oral anticancer medications, limited to cost sharing of $200 (for Co pay or Coinsurance) per prescription, up to a 30 day supply; and 25) any additional benefit mandated by the State of California currently not listed here. Please see the Policy on file with the College for further details.

To view the Policy please visit the following links:
MFA Graphic Design students: https://consolidatedhealthplan.com/group/537/home
All other students: https://consolidatedhealthplan.com/group/523/home
The Policy does not cover nor provide benefits for loss or expenses incurred:

1. As a result of dental treatment, except for treatment resulting from Injury to Natural Teeth or as provided under the Pediatric Dental Treatment Expense. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
2. For services normally provided without charge by the school or services covered by the school fee.
3. For eye examinations, eyeglasses, contact lenses, or prescription for such, except as specifically provided under Vision Care Expense and Pediatric Vision Care Expense; radial keratotomy or laser surgery; except as required for repair caused by a covered injury. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
4. For hearing examinations, except as specifically provided under Outpatient Doctor’s Fee Expenses.
5. As a result of an Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law. Any Medically Necessary Eligible Expenses provided for under the Policy and not paid for under any Workers’ Compensation or Occupational Disease plan, will be payable under the Policy. The total benefits paid under all plans cannot exceed 100% of the Eligible Expenses incurred.
6. As a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
7. For treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
8. For cosmetic surgery except as required to correct an Injury. "Cosmetic surgery" shall not include reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) improve function; or 2) create a normal appearance, to the extent possible; or 3) for which benefits are otherwise payable under the Policy. It also shall not include breast reconstructive surgery after a mastectomy.
9. For Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss for which mandatory automobile no fault benefits are paid. Any Medically Necessary Eligible Expenses provided for under the Policy and not paid for under mandatory automobile no fault benefits, will be payable under the Policy. The total benefits paid under all plans cannot exceed 100% of the Eligible Expenses incurred.
10. As a result of committing or attempting to commit a felony.
11. For elective treatment or elective surgery. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
12. After the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
13. For any services rendered by a Covered Person’s Immediate Family Member.
14. For a treatment, service, or supply which is not Medically Necessary.
15. For surgery and/or treatment of: acne; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; weak, strained, or flat feet; corns, calluses, and bunions; fallen arches, chronic foot strain or symptomatic complaints of the feet; routine care of toenails, except for care and treatment of an Injury; deviated nasal septum, including submucous resection and/or other surgical correction thereof except for purulent sinusitis; nonmalignant warts, moles, and lesions; nutrition programs; and weight reduction. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
16. For sterilization reversal; or for birth control except prescribed FDA approved contraceptive drugs and devices.
17. For impotence, organic or otherwise, except for prescriptions prescribed for the treatment of sexual dysfunction disorder; treatment of infertility, including diagnosis, diagnostic tests, surgery, or any other form of assisted conception; artificial insemination.
18. For treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
19. For treatment, services, drugs, devices, procedures, or supplies that are Experimental or Investigational, unless specifically provided under Clinical Trials Expense. In order to contest an Experimental or Investigational health care service that has been denied, the Covered Person may request an Independent Medical Review as provided under Section 9 - Independent Medical Review System of the Policy.
20. For treatment, service, or supply for which a charge would not have been made in the absence of insurance.
21. For hair growth or removal.
COORDINATION OF BENEFITS PROVISION

The Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverage under which the Covered Person is enrolled shall not exceed 100% of the cost of the covered services.

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the brochure.

**Accident** means an occurrence which: 1) is unforeseen; 2) is not due to Sickness or disease of any kind; and 3) causes Injury.

**Actual Charge** means the charge for the covered service by the provider who furnishes it.

**Allowable Charges** means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services, and supplies.

**Company** means the National Union Fire Insurance Company of Pittsburgh, Pa.

**Complications of Pregnancy** means a condition: (1) when pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from but is adversely affected or is caused by pregnancy, such as: (a) acute nephritis or nephrosis; (b) pre eclampsia; (c) puerperal infection; (d) RH Factor problems; (e) severe loss of blood requiring transfusion; (f) cardiac decompensation or missed abortion; and (g) other similar medical and surgical conditions of comparable severity related to pregnancy; or (2) when pregnancy is terminated: (a) non elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include: (a) false labor; (b) occasional spotting; (c) Doctor prescribed rest during the period of pregnancy; (e) morning sickness; and (f) similar conditions not medically distinct from a Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non elective. A cesarean section will be considered non elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if the cesarean section is not performed. A cesarean section section beyond one performed in any previous pregnancy will also be considered non elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the child or mother.

**Coinsurance** means the percentage of the Eligible Expense payable by the Covered Person under the Plan.

**Co pay** means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

**Covered Percentage** means the percentage of the Eligible Expense that is payable as a benefit under the Plan.

**Covered Person** means a Covered Student and his or her Dependent(s) insured under the Plan.

**Covered Student** means a student of the Policyholder who is insured under the Plan.

**Deductible/ Deductible Amount** means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

**Dependent** means: 1) the Covered Student's Spouse or Registered Domestic Partner residing with the Covered Student; and 2) the Covered Student's or Spouse's or Registered Domestic Partner's child until the date such child attains age 26.

The term "child" includes:

a) A legally adopted child;

b) A child who has been placed in the Covered Student’s or Spouse’s or Registered Domestic Partner’s home for the purpose of adoption, from the moment of placement as certified by the agency making the placement; and

c) A step child if such child depends on the Covered Student or Spouse or Registered Domestic Partner for full support.

The "child" of a Covered Student or Spouse or Registered Domestic Partner will not be denied enrollment under the Plan because he or she:

a) Was born out of wedlock;

b) Is not claimed as a dependent on the Covered Student's or Spouse's or Registered Domestic Partner federal tax return;

c) Does not reside with the Covered Student or Spouse or Registered Domestic Partner in the Plan's service area.

The term "child" includes a child of the Covered Student or Spouse or Registered Domestic Partner who is a non custodial parent. In such case, the Company will:

a) Provide information to the custodial parent as may be necessary for the child to obtain benefits applicable to Covered Dependents under the Plan;

b) Permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for Eligible Expenses without the approval of the non custodial parent; and

c) Make payments on claims directly to the custodial parent, health care provider or the social services district furnishing medical assistance to the child, whichever is applicable.
DEFINITIONS (Continued)

The term "child" also includes a child for whom the Covered Student is required by a court or administrative order to provide coverage. In the event such is the case, the Covered Student may apply to insure the child, if he or she is otherwise eligible for coverage, without regard to any enrollment requirements. Insurance will become effective for such child on the date the Company receives the request. If the Covered Student is eligible for dependent insurance but fails to apply to insure the child in accordance with the court or administrative order, such child will become insured on the date the Company receives the written request to insure the child from the child's other parent, the state agency administering the Medicaid program or the state agency administering the child enforcement program.

Doctor as used herein means: 1) a legally qualified physician licensed by the state in which he or she practices; and 2) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and 3) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's Immediate Family Member.

Durable Medical Equipment consists of, but is not restricted to, the following types of orthopedic or prosthetic devices or Hospital equipment: man made limbs or eyes for the replacing of natural limbs or eyes; casts, splints or crutches; curve handled or quad cane and replacement supplies; purchase of a truss or brace; oxygen and equipment for giving oxygen; wheelchair or hospital bed; infusion pumps and supplies; dialysis equipment and supplies, including but not limited to equipment and medical supplies required for home hemodialysis and home peritoneal dialysis; ostomy and urological supplies, including but not limited to colostomy bags and ureterostomy bags; dry pressure pad for a mattress; nebulizer and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; bone stimulator; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; two external post operative breast prostheses; traction equipment, and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non therapeutic and therapeutic use.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage. Elective treatment includes but is not limited to: breast reduction, unless as a result of mastectomy; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; botox injections; and treatment of infertility.

Eligible Expense as used herein means a charge for any treatment, service, or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury or Preventive Services: 1) not in excess of the Reasonable and Customary charges; or 1) not in excess of the charges that would have been made in the absence of this coverage; 3) with respect to the Preferred Provider, is the Allowable Charge; 4) is the negotiated rate, if any; and 5) incurred while the Policy is in force as to the Covered Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
1. Placing the Covered Person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. Serious jeopardy to the health of the fetus; or
6. A condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

Emergency Services means, with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.
DEFINITIONS (Continued)

**Essential Health Benefits** has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Experimental/Investigational** means a drug, device, or medical care/treatment that meets the following: 1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; 2) the informed consent document used with the drug, device, medical care, or treatment states or indicates that the drug, device, medical care, or treatment is part of a clinical trial, experimental phase, or investigational phase, if such a consent document is required by law; 3) the drug, device, medical care, or treatment or the patient’s informed consent document used with the drug, device, medical care, or treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval; 4) reliable evidence shows that the drug, device, medical care, or treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study, or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or 5) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care, or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care, or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care, or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care, or treatment at the time the expense is incurred.

**Habilitative Services** means Medically Necessary health care services and health care devices that assist a Covered Person in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with a Covered Person’s environment. Examples of health care services that are not Habilitative Services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

**Hospital** means a facility which meets all of these tests:

1. It provides in patient services for the care and treatment of injured and sick people; and
2. It provides room and board services and nursing services 24 hours a day; and
3. It has established facilities for diagnosis and major surgery; and
4. It is supervised by a Doctor; and
5. It is run as a Hospital under the laws of the jurisdiction in which it is located; and
6. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: a) as a convalescent home; b) as a nursing or rest home; c) as a place for custodial or educational care. The term "Hospital" includes: a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; b) an ambulatory surgical center or ambulatory medical center; c) a mental health hospital if supervised and licensed by the Department of Mental Health; and d) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax supported institutions, which are not required to maintain surgical facilities.

**Hospital Confinement/Hospital Confinement** means a stay of at least 18 consecutive hours for which a room and board charge is made.

**Immediate Family Member(s)** means a person who is related to the Covered Person in any of the following ways: 1) Spouse; 2) Registered Domestic Partner; 3) brother in law; 4) sister in law; 5) son in law; 6) daughter in law; 7) mother in law; 8) father in law; 9) parent (includes stepparent); 10) brother or sister (includes stepbrother or stepsister); 11 child (includes legally adopted or stepchild).

**Injury** means bodily injury due to an Accident which: 1) occurs after the Covered Person’s effective date of coverage; and 2) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

**Involuntary Loss of Coverage** means that prior coverage has been involuntarily terminated due to no fault of the Covered Student. Such includes coverage that terminates due to loss of employment by Spouse or Registered Domestic Partner or parent. It does not include coverage that has a predetermined termination date; expiration of COBRA eligibility; or coverage that has been voluntarily terminated.

**Intensive Care Unit** means a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.
Medically Necessary means a service that is medically appropriate and required to prevent, diagnose, or treat the Covered Person's condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Mental Disorder is a mental health condition identified as a "Mental Disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental Disorders include the following conditions:

1. **Severe Mental Illness of a person of any age.** "Severe Mental Illness" means the following Mental Disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

2. **A Serious Emotional Disturbance of a child under age 18.** A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a Mental Disorder in the DSM, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
   a. as a result of the Mental Disorder, 1) the child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships, or ability to function in the community; and 2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;
   b. the child displays psychotic features, or risk of suicide or violence due to a Mental Disorder; or
   c. the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 2 of the California Code.

Natural Teeth means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Natural Teeth will not include capped teeth.

One Sickness means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

Orthopedic Brace and Appliance means a supportive device or appliance used to treat a Sickness or Injury.

Physiotherapy means any form of the following administered by a Doctor for treatment of Sickness or Injury: physical or mechanical; diathermy; ultra sonic therapy; heat treatment in any form; or manipulation or massage.

Policy Year means the period of time measured from the Policy Term Effective Date to the Policy Term End Date.

Policyholder means Otis College of Art and Design.

Pre Admission Testing means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person's condition in anticipation of a scheduled Hospital Confinement; a Hospital bed has been reserved before the tests are made; and the Covered Person is physically present for the tests. In the event pre admission testing is ordered by the attending Doctor and the Hospital Confinement is subsequently canceled, benefits for pre admission testing and services already performed will be covered and benefits will be payable under the Plan based on the available coverage.

Pre Certification means a method by which insurance companies monitor utilization through prior notification to the plan of services to be rendered.

Preventive Services mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost sharing requirements, such as deductibles, co payment amounts, or coinsurance amounts to any Covered Person receiving any of the following:

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, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

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 Covered Person involved;

3. With respect to infants, children, and adolescents, evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.
DEFINITIONS (Continued)

Reasonable and Customary ("R&C") means the charge, fee, or expense which is the smallest of: 1) the Actual Charge; 2) the charge usually made for a covered service by the provider who furnishes it; 3) the negotiated rate, if any; and 4) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

Geographic area means the three digit ZIP code in which the services, procedure, devices, drugs, treatment, or supplies are provided or a greater area, if necessary, to obtain a representative cross section of charge for a like treatment, service, procedure, device, drug, or supply.

Reasonable and Customary charges also means the percentile of the payment system in effect on the Policy Term Effective Date.

Registered Domestic Partner means a person who is a party to and files a Declaration of Domestic Partnership with the Secretary of State of California establishing a domestic partnership with another person, subject to the following requirements:
1. Neither person is married to someone else;
2. Neither person is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
3. Neither person is related to the other person in the partnership by blood in a way that would prevent them from being married to each other in California;
4. Both persons are at least 18 years of age, unless a court order granting permission and written consent of the parents or guardian of the person under age 18 is filed with the Declaration of Domestic Partnership;
5. Both persons are the same sex, or if opposite sex, at least one person is over 62 years of age; Both persons are capable of consenting to the domestic partnership

Sickness means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

Spouse means the person to whom the Covered Student is married.

Student Health Center means any organization, facility or clinic owned, operated, maintained or supported by the Policyholder.

TRAVEL GUARD®

Description of Travel Assistance Services for Students

Wherever your travels may take you, in the event of a medical emergency or unexpected travel problem, Travel Guard is never more than a phone call away. Our state of the art service centers deliver global service 24 hours a day, 7 days a week, 365 days a year.

How to contact Travel Guard:
Inside the United States and Canada, dial toll free +1 877 249 5362
Outside the U.S. and Canada:
• Request an international operator.
• Request the operator to place a collect call to the U.S. at +1 715 295 9625.

Email us at assistance@aig.com

When to contact Travel Guard:
• If you require medical assistance or have a medical emergency.
• If you need assistance with a non medical situation such as lost luggage, lost documents or other travel issues.

Helpful information to have available when you call Travel Guard:
• Policy number or school name
• Nature of your call and/or emergency
• Current location
• Contact phone number and email address
• Secondary point of contact
• Date of birth

Travel Medical Assistance
From physician referrals to coordinating medical evacuations, we help traveling students address their medical needs with expediency and expert care:
• Coordinate medical evacuation arrangements
• Physician/hospital/dental/vision care referral details, when medical attention is required including assistance with appointments
• Coordination of repatriation arrangements for the return of mortal remains in accordance with local governmental procedures
• Assistance with emergency prescription replacement while abroad

General Travel Assistance

Flight delays, inclement weather, lost or stolen luggage and other travel hassles are an unfortunate reality of travel today. We keep traveling students on the move with a variety of travel assistance services:

• Lost or stolen documents assistance
• Embassy and consulate information and referrals
• Lost baggage search and luggage replacement assistance
• Emergency language interpretation and translation services
• Emergency cash transfer assistance
• Legal referrals/bail bond assistance
• Foreign exchange, ATM and weather information

• Emergency return travel arrangements
• Flight and hotel re bookings
• Immunization, visa and passport information
• Guaranteed hotel check in
• Travel delay reports
• Worldwide public holiday information
• Urgent message relay to family, friends or university associates

Travel Concierge Services

Whether it is finding local restaurants or concert tickets, our Concierge Desk is a direct line to a team of professional and personal assistants available to help your travels be more effective:

• Referrals for counselling services
• Restaurant or local activity assistance Recommendations for spring break
• Moving coordination assistance
• Locate laundry facilities, post offices or bus schedules
• Recommend local car maintenance assistance
• Concert and event ticketing
• Electronic and wireless device assistance
• Movie and theatre information and ticketing
• Assistance with locating low fuel prices
• Assistance with finding places to purchase room supplies
• Locating retail stores (including shopping, coffee shops with free wireless internet access)

Travel Assistance Website and Mobile App

You can access our secure website, an online resource to stay a step ahead with the latest travel, security and health information. Whether it’s prior to travel, during the trip, or after the return home, our members only assistance website provides student travelers access to in depth travel, health and security information. You can connect to the travel assistance website from your computer, smartphone or tablet 24/7/365. Please visit www.aig.com/us/travelguardassistance for more information about the website and mobile app.

• Email alerts contain security developments, such as terror attacks, major strikes, disasters or disruptions and government warnings that may affect your travel destination(s) and specific travel dates.
• Country reports provide key information on political conditions, security issues, travel logistics and cultural considerations.
• The Travel Health section educates travelers on health related concerns, precautions and requirements for destinations and ability to create personal travel health profiles.
• The Medical Translations tool translates medical terms and phrases into multiple languages.
• The Drug Brand Equivalency tool generates drug brand names and their equivalent names in multiple countries.
• Security Awareness Training provides online travel safety videos and knowledge tests provide basic tools and information to be an aware, organized and prepared traveler.

About AIG Travel and Travel Guard®

AIG Travel, Inc., a member of American International Group, Inc., is a worldwide leader in travel insurance solutions and assistance. Travel Guard® is the marketing name for its portfolio of travel insurance solutions and travel related services, including assistance and security services, marketed to both leisure and business travelers around the globe. Services are provided through a network of wholly owned service centers located in Asia, Europe and the Americas. For additional information, please visit our websites at www.aig.com/travel and www.travelguard.com.
ASK MAYO CLINIC
(Ask Mayo is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)
Students who enroll and maintain medical coverage in the Plan have access to a 24 hour nurse line administered by Ask Mayo Clinic. This program provides:
• Phone based, reliable health information in response to health concerns and questions; and
• Assistance in decisions on the appropriate level of care for an injury or sickness.
Appropriate care may include self care at home, a call to a Doctor, or a visit to the emergency room.
Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.
This program is not a substitute for Doctor visits or emergency response systems. Ask Mayo Clinic does not answer health plan benefit questions. Health benefit questions should be referred to Consolidated Health Plan at 1 800 633 7867. The Ask Mayo Clinic 24 hour nurse line toll free number will be on the ID card.

CLAIM PROCEDURE
1) If the Covered Person experiences a Sickness or Injury, he or she should go to the nearest PPO Doctor's office, urgent care, or Hospital. While the Covered Person may choose any Doctor or Hospital, using the providers available through the PPO network may greatly decrease the Covered Person's costs. For a complete listing of the PPO Doctor or Hospital facilities, visit www.cigna.com.
2) If the Covered Person needs to be admitted to a Hospital for a planned surgery or inpatient treatment, Pre Certification is required at least 5 days prior to planned admission or within 2 days after Emergency admission. For Pre Certification prior to hospitalization, the Covered Person's Doctor must call Consolidated Health Plans at 1 800 633 7867
3) If the Covered Person goes to a Doctor's office or to the Hospital, he or she should bring his or her insurance identification card. If the Doctor or Hospital needs to verify coverage, they may call Consolidated Health Plans at 1 800 633 7867. Carry your insurance ID card with you at all times.
4) If the Covered Person receives treatment at a PPO provider, his or her provider will submit a claim to the insurance company. The provider will then bill the Covered Person for any charges that the insurance doesn't cover. Providers should submit claims directly to Cigna at PAYER ID 62308, or mail to the following address: Cigna, P.O. Box 188061, Chattanooga, TN 37422 8061.
5) In some circumstances, such as using a non PPO provider, the Covered Person may be asked to pay up front. In this case, the Covered Person must submit a claim for reimbursement for the portion of the charges the Company is responsible for paying. Follow these steps:
   b) Answer all the questions and be sure to sign the claim form before submitting it.
   c) If the Covered Person has expenses such as X rays, or laboratory charges, he or she should attach these bills to the claim form.
   d) The Covered Person should send all itemized Hospital and medical bills, along with a completed claim form, to:
      Cigna
      P.O. Box 188061
      Chattanooga, TN 37422 8061
      Electronic Payor ID: 62308
6) If the Covered Person has questions about the status of his or her claim after it has been submitted, he or she should call Consolidated Health Plans at 1 800 633 7867.
All Hospital and medical bills must be submitted to Cigna for payment within 90 days after the first date of treatment. Failure to furnish this information within the 90 day period shall not invalidate nor reduce the Covered Person's claim if it was not reasonably possible to file the claim within this time, provided that the claim is submitted as soon as is reasonably possible. In no event, except in the absence of legal capacity, will a claim be honored later than one (1) year from the date of last medical treatment.

Covered Persons have the right to file a written complaint with the Company and obtain an expedited review if they believe health care services have been improperly denied, modified, or delayed. Send your written complaint Consolidated Health Plans at the following address:

2077 Roosevelt Avenue
Springfield, MA 01104
800 633 7867

Always keep a copy of all documents submitted for claims.
CERTIFICATE OF CREDITABLE COVERAGE

The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Policy is terminated. In addition, Certificates of Creditable Coverage shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time. In order to obtain a Certificate of Creditable Coverage, please contact Consolidated Health Plans at 800 633 7867.

At AIG, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.AIG.com.

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