Goldey-Beacom College
(“the Policyholder”)

2016 – 2017
Student Health Insurance Plan
(“the Plan”)

Administrator Group Number: S212216
Underwriter Reference Number: CAS9151251

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

Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-DE. The Policy on file at the College contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this brochure and the Policy, the Policy shall govern. A copy of the Policy will be available to the Covered Student in his or her online account at www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579 or upon request. Travel Assistance services provided by Travel Guard Group, Inc. (“Travel Guard”). Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.
STUDENT HEALTH INSURANCE PLAN ELIGIBILITY

All students living on campus, all international students and all intercollegiate athletes are eligible for coverage and will be automatically enrolled in and charged premium for the Goldey-Beacom College Student Health Insurance Plan ("the Plan") unless coverage under the Plan is waived by providing proof of comparable coverage under another health insurance plan by the waiver deadline. Students who are currently insured under a comparable health insurance plan may waive coverage under the Plan by completing the online waiver form at https://web01.gbc.edu/student_affairs/healthinsform.asp by the waiver deadline of August 1, 2016. If the online waiver is not completed by the waiver deadline the cost of coverage will be included on the student's tuition bill.

Eligible students who are enrolled in the Plan may also enroll their eligible Dependents. An eligible Dependent is the Covered Student’s Spouse residing with the Covered Student and the Covered Student’s or Spouse’s child until the date such child attains age 26, provided such child is not provided coverage under an employer-sponsored health plan through his or her own employment. Dependents must be enrolled for the same coverage as the student, and the last date to enroll Dependents for coverage is September 25, 2016. A Dependent may become eligible for coverage under the Plan only when the student becomes eligible or within 31 days of marriage, birth or adoption.

To enroll a Dependent:

- Select the Enroll tab, then Dependent Enrollment tab to sign in to your account
- Select Student Options, then select Add Dependents. Enter all information for Dependents and submit payment via credit card.

Matriculating students who live off campus are eligible for coverage and may enroll in the Plan voluntarily by visiting cirstudenthealth.com/gbc and selecting the Health Insurance Enroll/Waive tab to access the voluntary enrollment form. The last date to enroll for the annual coverage is September 25, 2016.
2016 – 2017 STUDENT HEALTH INSURANCE PLAN COSTS*

<table>
<thead>
<tr>
<th>Term of Coverage</th>
<th>Annual 8/12/16 - 8/12/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,129</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,129</td>
</tr>
<tr>
<td>Each Child**</td>
<td>$1,129</td>
</tr>
</tbody>
</table>

*Plan costs include administrative fees.

**Premium is charged per child, up to 3 times the premium fee, after which no further premium is charged for additional children.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility under another creditable coverage. If you experience ineligibility under another creditable plan, please email proof of ineligibility to qualifier@studentinsurance.com.

An eligible student must actively attend classes at the Policyholder’s school for at least the first 30 days of the period for which he or she is enrolled. Students who withdraw after such 30 days will remain covered under the Plan and no refund will be made. The Company maintains the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been met. If it is discovered that the Plan eligibility requirements have not been met, the Company’s only obligation is to refund premium, less any claims paid.

**EFFECTIVE AND TERMINATION DATES**

The Policy becomes effective at 12:01 a.m. August 12, 2016.

**Students Automatically Enrolled:**

The coverage of an eligible student, including the student who initially waived coverage and subsequently enrolls within 31 days of ineligibility under another creditable 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 Policyholder’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 Policyholder.

**Students Enrolling on a Voluntary Basis:**

The coverage of an eligible student who enrolls for coverage under the Policy during an initial Open Enrollment Period shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the date for which the first premium for the Covered Student’s coverage is received by the Company; (3) the date the Policyholder’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 Policyholder.

However, a student who does not enroll himself or herself during an Open Enrollment Period may not apply for coverage until the next subsequent Open Enrollment Period.

The Policy terminates at 12:01 a.m. August 12, 2017.

Insurance for a Covered Student will end at 12:01 a.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 (a full refund of premium will be made (less any claims paid) when written request is made).

If withdrawal from the Policyholder’s school is for other than (a) or (b) above, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled and for which premium has been paid.

Insurance for a Covered Student’s Dependent will end when insurance for the Covered Student ends unless otherwise provided in the Policy.
EXTENSION OF BENEFITS

If, on the date coverage terminates, a Covered Person is Totally Disabled as a result of Sickness or Injury and is receiving treatment for such Sickness or Injury, benefits will be payable for the Eligible Expenses incurred for that Sickness or Injury after the date coverage terminates until the earliest of the following: (1) the end of the Sickness or Injury that caused the Total Disability; (2) the end of the 90 day period following the date coverage terminated; or (3) the date the applicable Maximum Amount is reached.

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

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, request one online at www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579 or contact:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
877-657-5030

DEFINITIONS

Whenever used in the Policy:

“Accident” means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

“Act” means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the HealthCare and Education Reconciliation Act of 2010 (Public Law 111-152).

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

“Complications of Pregnancy” means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; or
- pre-eclampsia; or
- -eclampsia; puerperal infection; or
- -RH Factor problems; or
- -severe loss of blood requiring transfusion; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum; and (d) similar conditions not medically distinct from a difficult pregnancy. Complications of Pregnancy also include:

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

“Coinsurance” means the percentage of the Eligible Expense payable by the Covered Person under the Policy.

“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 Policy.

“Covered Person” means a Covered Student while coverage under the Policy is in effect.

“Covered Student” means a student of the Policyholder who is insured under the Policy.

“Deductible/Deductible Amount” means the dollar amount of Eligible Expenses a Covered Person must pay during each Policy Year before benefits become payable.

“Dependent” means: (a) the Covered Student’s Spouse residing with the Covered Student; and (b) the Covered Student’s or Spouse’s child until the date such child attains age 26, provided such child is not provided coverage under an employer-sponsored health plan through his or her own employment.

The term “child” includes:
(a) a legally adopted child;
(b) a child who has been placed for purposes of adoption in the Covered Student’s or Spouse’s home pending adoption procedures; and
(c) a step-child if such child depends on the Covered Student or Spouse for full support.

The “child” of a Covered Student or Spouse will not be denied enrollment under the Policy 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 federal tax return; and
(c) does not reside with the Covered Student or Spouse in the Policy’s service area.

“Doctor” as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) 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 (c) 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 initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs 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: vasectomy; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; learning disabilities; 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:
(a) not in excess of the Reasonable and Customary charges; or
(b) not in excess of the charges that would have been made in the absence of this coverage;
(c) with respect to the Preferred Provider, is the Allowable Charge;
(d) is the negotiated rate, if any; and
(e) 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 or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
(a) placing the health or pregnancy of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
(b) serious impairment to such person’s bodily functions;
(c) serious impairment or dysfunction of any bodily organ or part of such person;
(d) serious disfigurement of such person.

“Emergency Services” means, with respect to an Emergency Medical Condition: (a) 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 (b) 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.

“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 or treatment that meets the following:
(a) 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;
(b) 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;
(c) 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;
(d) reliable evidence shows that the drug, device or 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
(e) 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 or 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.

“Hospital” means a facility which meets all of these tests:
(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
(f) 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; or (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 Confined” 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: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) 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.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:
(a) it is provided only as a convenience to the Covered Person or provider; or
(b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis.
Sickness also includes any form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

“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, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:
(a) 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;
(b) 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;
(c) 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
(d) 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.

“Reasonable and Customary” (“R&C”) means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) 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 Effective Date shown in the Schedule of Benefits in the Policy on file with the Policyholder.

“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.
“Sound 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. Sound Natural Teeth will not include capped teeth.

“Spouse” means the Covered Student’s legal Spouse or partner to a civil union.

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

“Totally Disabled” and “Total Disability” means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a Covered Student: from attending classes at the location where he or she is enrolled; and (b) with respect to a Dependent or student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex.

**GOLDEY-BEACOM COLLEGE SCHEDULE OF BENEFITS**

This Plan would satisfy the Gold Level – Actuarial Value 83.8%.

Aggregate Maximum Benefit per Policy Year per Covered Person: UNLIMITED

Preferred Provider Organization (PPO): First Health Network

The medical benefits stated in the Plan are based upon medical treatment being received from a Preferred Provider Organization (PPO). If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the percentage shown for Non-PPO in the Schedule of Benefits below. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or facility to which the Covered Person is referred is also a PPO provider. It is the Covered Person’s responsibility to verify that the provider is part of the PPO. A list of providers in the First Health Network is available for review via the “Preferred Provider Lookup” that can be accessed at www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579

<table>
<thead>
<tr>
<th>ELIGIBLE EXPENSES</th>
<th>IN-NETWORK</th>
<th>OUT- OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Amount per Policy Year</td>
<td>Individual: $0</td>
<td>Individual: $50</td>
</tr>
<tr>
<td></td>
<td>Family: $0</td>
<td>Family: $100</td>
</tr>
<tr>
<td>Out-of-Pocket Limit per Policy Year</td>
<td>Individual: $5,000</td>
<td>Individual: $10,000</td>
</tr>
<tr>
<td>The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which the Covered Person is responsible due to Covered Percentages being less than 100%, reach the Out-of-Pocket Limit. 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 (“R&amp;C”); charges in excess of any specified maximum; or charges incurred for any services not covered under the Policy. When this benefit 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 shown, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible Expenses 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.</td>
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<table>
<thead>
<tr>
<th>INPATIENT BENEFITS</th>
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<tbody>
<tr>
<td>Daily Room and Board Maximum, limited to the average semi-private rate</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Description</td>
<td>Coverage</td>
<td>Co-payment</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>Miscellaneous Hospital Expense, includes expenses incurred for anesthesia</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>and operating room; laboratory tests and X-rays; oxygen tent; drugs,</td>
<td>Charges</td>
<td>R&amp;C</td>
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<tr>
<td>medicines (excluding take-home drugs), dressings; and other Medically</td>
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<tr>
<td>Necessary and prescribed Hospital expenses.</td>
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</tr>
<tr>
<td>Maternity</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Pre-admission Testing (Hospital Confinement must occur within 3 days of</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>the testing.)</td>
<td>Charges</td>
<td>R&amp;C</td>
</tr>
<tr>
<td>Private Duty Nursing, rendered by a Registered Nurse (RN) or Licensed</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Practical Nurse (LPN) provided such care is: (a) rendered during Hospital</td>
<td>Charges</td>
<td>R&amp;C</td>
</tr>
<tr>
<td>Confinement; (b) Medically Necessary; and (c) no other charge is made for</td>
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<tr>
<td>such service.</td>
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<tr>
<td>Physiotherapy during Hospital Confinement</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Surgical Expense, when Injury or Sickness requires two or more surgical</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>procedures which are performed through the same incision, and at the same</td>
<td>Charges</td>
<td>R&amp;C</td>
</tr>
<tr>
<td>operative session or immediate succession, the Company will pay only for</td>
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<tr>
<td>the most expensive when multiple procedures are performed, except when</td>
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<tr>
<td>Medically Necessary.</td>
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<tr>
<td>Anesthesia</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>In-Hospital Doctor’s Fees Expense, limited to one visit per day and not</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>related to Physiotherapy.</td>
<td>Charges</td>
<td>R&amp;C</td>
</tr>
<tr>
<td>Psychiatric Conditions Expense (Severe Mental Illness/Mental and Nervous</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Disorders)</td>
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<tr>
<td>Alcoholism and Substance Abuse Expense</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
</tbody>
</table>

**OUTPATIENT BENEFITS**

<table>
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<td>50% of R&amp;C</td>
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<tr>
<td>the most expensive when multiple procedures are performed, except when</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous, when scheduled surgery is performed in</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>a Hospital or outpatient facility or ambulatory surgical center, including:</td>
<td>Charges</td>
<td>R&amp;C</td>
</tr>
<tr>
<td>use of the operating room; laboratory tests and x-ray examinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including professional fees); anesthesia; infusion therapy; drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or medicines and supplies; therapeutic services (excluding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy or take home drugs and medicines).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Surgical Only, other outpatient services performed in a Hospital</td>
<td>70% of Allowable</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>including, but not limited to:</td>
<td>Charges</td>
<td>R&amp;C</td>
</tr>
<tr>
<td>diagnostic x-ray and laboratory services; radiation therapy and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chemotherapy; diagnostic services and medical procedures performed by the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor (other than Doctor’s visits, Physiotherapy, x-rays and laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>procedures).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Allowable Charges</td>
<td>R&amp;C 50% of</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Hospital emergency room, including attending Doctor's charges, operating room, laboratory and x-ray examinations, supplies. Co-pay waived if Covered Person is admitted to the Hospital as an inpatient.</td>
<td>70% of Allowable Charges, subject to a $100 Co-pay per visit</td>
<td>50% of R&amp;C, subject to a $100 Co-pay per visit</td>
</tr>
<tr>
<td>Preventive Services mandated by the Patient Protection and Affordable Care Act. Includes preventive services such as screenings, exams, and immunizations. To view a list of covered preventive services, log onto: <a href="http://www.hhs.gov/healthcare/prevention/index.html">www.hhs.gov/healthcare/prevention/index.html</a></td>
<td>100% of Allowable Charges, Not subject to Deductible or Co-pay amounts.</td>
<td>60% of R&amp;C Subject to Deductible or Co-pay amounts.</td>
</tr>
<tr>
<td>Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>CAT Scan/MRI and/or PET Scan</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment and Orthopedic Appliance. No benefits will be payable for rental charges in excess of the purchase price. Replacement not covered.</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Braces and Appliances, benefits are payable only upon Doctor’s written prescription.</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>For Diagnostic Services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and lab procedures (not otherwise covered under Preventive Benefits)</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitation Services/Habilitative Services (physical therapy/Physiotherapy, occupational therapy, chiropractic care, cardiac/pulmonary, speech and hearing therapy)</td>
<td>70% of Allowable Charges subject to a $15 Co-pay per visit</td>
<td>50% of R&amp;C subject to a $25 Co-pay per visit</td>
</tr>
<tr>
<td>*Benefits are payable for a condition that required surgery or Hospital Confinement: (1) within 30 days immediately preceding such physiotherapy; or (2) within 30 days immediately following the attending Doctor’s release for rehabilitation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis and Filtration Procedures</td>
<td>70% of Allowable Charges subject to a $15 Co-pay per visit</td>
<td>50% of R&amp;C subject to a $25 Co-pay per visit</td>
</tr>
<tr>
<td>Intravenous Home Therapy</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Out of Hospital Doctor’s Fees Expense*</td>
<td>70% of Allowable Charges subject to a $10 Co-pay per visit</td>
<td>50% of R&amp;C, subject to a $10 Co-pay per visit</td>
</tr>
<tr>
<td>Doctor (other than Specialist) / Specialist*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to one visit per day. More than one visit per day may be allowed, provided the 2nd and subsequent visits are not with the same Doctor. *Specialist – a Doctor whose practice is limited to a particular branch of medicine. *Benefits do not apply with related to surgery. *Includes injections when administered in the Doctor’s office.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor – Urgent Care Facility</td>
<td>70% of Allowable Charges subject to a $15 Co-pay per visit</td>
<td>50% of R&amp;C subject to a $25 Co-pay per visit</td>
</tr>
<tr>
<td>Consultant’s Fees Expense</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Ambulance Expense</td>
<td>70% of R&amp;C</td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>Dental Treatment Expense (Injury Only)</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Pediatric Dental Treatment Expense (for Covered Persons under age 19 only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Pay Amount per visit</td>
<td>$10</td>
<td></td>
</tr>
<tr>
<td>Covered Percentage:</td>
<td></td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>For Diagnostic/Preventive Services</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>For Basic Services</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>For Primary/Major Services</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>For Orthodontic Services</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
</tbody>
</table>

This coverage does not include orthodontic services for which treatment began prior to the effective date, nor will benefits be paid for gold foil restoration, gold fillings, inlays, crowns, bridges, and dentures.

Please see the complete Policy on file with the Policyholder for full details.

<table>
<thead>
<tr>
<th>Prescribed Medicines Expense, prescriptions must be filled at an OptumRx participating pharmacy. A directory of participating pharmacies is available online at <a href="http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579">www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579</a> or call the pharmacy contact OptumRx’s pharmacy help desk at 1-800-880-1188.</th>
<th>100% of R&amp;C, subject to the following Co-pays per prescription or refill (limited to a 30 day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic: $10</td>
<td></td>
</tr>
<tr>
<td>Formulary Brand Name: $30</td>
<td></td>
</tr>
<tr>
<td>Non-Formulary Brand Drug: $30</td>
<td></td>
</tr>
<tr>
<td>Specialty Brand Drugs: $50</td>
<td></td>
</tr>
</tbody>
</table>

This benefit applies to all prescribed FDA-approved birth control methods. The Co-pay will be waived for prescribed FDA-approved birth control.

<table>
<thead>
<tr>
<th>Psychiatric Conditions Expense</th>
<th>Paid the same as any other Sickness</th>
<th>Paid the same as any other Sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Severe Mental Illness/Mental and Nervous Disorders)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcoholism and Substance Abuse Expense</th>
<th>Paid the same as any other Sickness</th>
<th>Paid the same as any other Sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Care Expense (for all Covered Persons age 19 and over)</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>(Benefits limited to one routine eye exam per Policy Year; one pair of lenses per Policy Year; and one frame per Policy Year)</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Vision Expense (for Covered Persons under age 19 only)</th>
<th>$10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Benefits limited to one routine eye exam per Policy Year: one pair of lenses per Policy Year: and one frame per Policy Year)</td>
<td>$10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Care Expense – limited to 60 visits per Policy Year</th>
<th>70% of Allowable Charges</th>
<th>50% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care Expense</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Urgent Care Expense</td>
<td>70% of Allowable Charges, subject to a $10 Co-pay per visit</td>
<td>50% of R&amp;C, subject to a $10 Co-pay per visit</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>70% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
</tbody>
</table>
REPATRIATION OF REMAINS AND MEDICAL EVACUATION

REPATRIATION OF REMAINS – Maximum Amount of $1,000,000

If a Covered Person suffers loss of life due to injury or emergency Sickness while outside his or her home country the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount 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 15 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

MEDICAL EVACUATION – Maximum Amount of $1,000,000

The Company will pay, subject to the limitations set out herein, for eligible Medical Evacuation expenses reasonably incurred if the Covered Person suffers an injury or emergency Sickness that warrants his or her Medical Evacuation while outside his or her home country but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes.

The Doctor ordering the Medical Evacuation must certify: (a) that the severity of the Covered Person’s injury or emergency Sickness warrants his or her Medical Evacuation; and (b) the Covered Person has been Hospital confined for at least five (5) consecutive days prior to Medical Evacuation.

Companion Assist

If the Covered Person is Hospital Confined due to an injury or emergency Sickness for more than seven (7) days while he/she is outside a 100 mile radius from his/her current place of primary residence, the Company will pay up to a maximum benefit of $20,000 for the cost of one economy round trip air fare ticket and the hotel accommodations (standard room charges only) for one (1) person designated by the Covered Student to the place where the Covered Student is Hospital Confined. No more than one (1) visit may be made during any Policy Year. No benefits are payable under this provision prior to the end of the seven (7) days of Hospital Confinement. No benefits are payable unless the trip is approved in advance by Travel Guard.

The amount of this benefit is subject to, when added to all benefits paid for Medical Evacuation under the Policy, the Medical Evacuation Expense Benefit Maximum Amount.

Travel Guard must make all arrangements and must authorize all expenses in advance for any 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 15 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

NON-DUPLICATION OF COVERAGE UNDER THE POLICY

If the benefits above are payable under more than one provision in the Policy, then benefits will be provided only under the provision providing the greater benefit.

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 coverages under which the Covered Person is enrolled shall not exceed 100% of the cost of the covered services.

STATE MANDATED BENEFITS

The Plan covers all applicable state mandated benefits. Please see the Policy on file with the Policyholder, or log into your secure Student account at www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579 for full details.
EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for loss or expenses incurred:
1. As a result of dental treatment, or dental x-rays except as provided elsewhere in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
2. For services normally provided without charge by the Policyholder’s Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder.
3. For eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy; hearing aids; or treatment for visual defects and problems. “Visual defects” means any physical defect of the eye which does or can impair normal vision apart from the disease process. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
4. As a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
5. For Injury or Sickness resulting from war or act of war, declared or undeclared.
6. As a result of an Injury or Sickness for which the Covered Person is entitled to benefits under any Workers’ Compensation or Occupational Disease Law.
7. 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.
8. For treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. For cosmetic surgery. “Cosmetic surgery” shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. It also shall not include breast reconstructive surgery after a mastectomy.
10. As a result of committing or attempting to commit an assault or felony or participation in a riot or insurrection.
11. For Elective Treatment or elective surgery or complications arising therefrom except as specifically provided in the Policy.
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 any treatment, service or supply which is not Medically Necessary.
15. As a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
16. For surgery and/or treatment of allergy, including allergy testing and anti-toxins; deviated nasal septum, including submucous resection and/or other surgical correction thereof except for purulent sinusitis; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; nonmalignant warts, moles and lesions. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
17. for Injury resulting from travel in, or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle, bobsledding or bungee jumping.
18. for outpatient Physiotherapy except as specifically provided under the Policy.
19. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports; activity, including travel to and from the activity and practice; scuba diving; hang gliding; parasailing; sky diving; flight in an ultra light aircraft; glider flying; sail planing; parachuting; or ballooning
20. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
22. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
23. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
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
  • Dispatch of doctor or specialist
  • In-patient and out-patient medical case management
  • Arrangements of visitor to bedside of hospitalized insured
  • Eyeglasses and corrective lens replacement assistance

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 return travel arrangements
  • Flight and hotel re-bookings
  • Immunization, visa and passport information
  • Guaranteed hotel check-in
  • Travel delay reports
  • Emergency cash transfer assistance
- Legal referrals/bail bond assistance
- Foreign exchange, ATM and weather information
- 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.com 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](http://www.aig.com/travel) and [www.travelguard.com](http://www.travelguard.com).

**CLAIM PROCEDURES**

In the event of Injury or Sickness, the Covered Person should:

1. Report at once to the nearest Doctor or Hospital.
2. Complete a Company claim form, available online at [www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579](http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579), and either mail or submit online (see below) all medical and Hospital bills along with the Covered Person’s name, address, social security number and name of the college insurance plan under which the Covered Person is insured.
3. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of an loss covered by the Policy, or as soon as was reasonably possible.

Claims can be accepted directly from Doctors and medical facilities if the claim includes the name of the Covered Person, Covered Student’s school name, date of services, diagnosis, treatment procedure and billed charges. Proof of loss must be furnished to the Company within 90 days after the date of such loss.
Claims can be submitted online at [www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579](http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=579) or mailed to the address below. If mailing, fill in the necessary information and mail all itemized medical and Hospital bills to the following address:

**Consolidated Health Plans (EDI # 87843)**

2077 Roosevelt Ave.

Springfield, MA 01104

Questions regarding benefits, specific claim information and periods of coverage should be directed to the address above or by calling the following Customer Service phone number: **(877) 657-5030**

**Claims Questions:**

Consolidated Health Plans

Toll Free: **(877) 657-5030**


**Plan Administrator**

Consolidated Health Plans

2077 Roosevelt Avenue

Springfield, MA 01104

(877)-657-5030

**SCHOOL’S BROKER**

USI Affinity Collegiate Insurance Resources

3070 Riverside Dr.

Columbus, OH 43221

Phone: 1-800-322-9901

Website: [www.cirstudenthealth.com/gbc](http://www.cirstudenthealth.com/gbc)

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 privacy information, please go to the website at [www.AIG.com](http://www.AIG.com).

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