



Domestic Comprehensive Health Insurance Plan (the "Plan")

2013 - 2014

State University & Community College
System of Tennessee
(“the Policyholder”)

Customer Service
Questions : 1-888-722-1668
Email: tbr@studentinsurance.com

www.studentinsurance.com

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

Administrator Policy # CHH0086874
Underwriter Reference # CAS9495427

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ELIGIBILITY

All domestic students enrolled for classes at a Community College, Technology Center, or University in the State University and Community College System of Tennessee are eligible to enroll in this Plan. Students must be enrolled for at least six (6) credit hours to be eligible for participation in this Plan. The six (6) credit hours requirement will not apply to students who are physically and/or mentally disabled. Such disability must be certified by the attending Doctor. An eligible student must actively attend classes at this Policyholder’s school for at least the first 30 days of the period for which he or she is enrolled. Home study, correspondence and television (TV) courses do not fulfill the eligibility requirements that the student actively attended classes. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that this Plan’s eligibility requirements have been met. If it is discovered that this Plan’s eligibility requirements have not been met, the Company’s only obligation is to refund premium less any claims paid.

DEPENDENTS

Eligible students who enroll in the Plan may also enroll their eligible dependents. Eligible dependents are: (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. A dependent may become eligible for coverage under the Policy only when the student becomes eligible; or within 31 days of marriage, birth or adoption.

ENROLLMENT

An eligible student may enroll for coverage for himself or herself only under the following conditions: (a) during an open enrollment period (the first 31 days of the Fall or Spring/Summer coverage terms); or (b) with respect to the new student who arrives in the United States, within 31 days of his or her arrival (proof is required at the time enrollment is submitted); or (c) within 31 days of a marriage, birth or adoption of a child; or (d) as a transfer student, within 31 days of the date of transfer; or (e) within 31 days of ineligibility under another creditable coverage and exhaustion of all available COBRA or continuation coverage.

Health care reform law notice

Your student health insurance coverage, offered by National Union Fire Insurance Company of Pittsburgh, Pa., may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012, and \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: \$500,000 on Essential Health Benefits. If you have any questions or concerns about this notice, contact **AIG, Educational Markets, at 1-888-722-1668. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.**

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m., August 1, 2013. The coverage of an eligible student who enrolls during an open enrollment period for coverage under this Plan shall take effect at 12:01 a.m. 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.

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 unless application for coverage is made within 31 days of ineligibility under another creditable coverage. As a result of ineligibility under another creditable coverage, the student may enroll for coverage for himself or herself. In that case, the insurance for the eligible student becomes effective on the latest of the following dates: (1) the day after the date on which the first premium for the Covered Student's coverage is received by the Company; or (2) 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; or (3) the date the Company gives its written consent.

The Master Policy terminates at 11:59 p.m., August 24, 2014. Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur: (a) the date the Policy terminates*; (b) the last day for which any required premium has been paid; (c) the date on which the Covered Student withdraws from the school because of: (1) 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 (2) withdrawal from school during the first 30 days of the period for which enrollment was made.

If withdrawal from the Policyholder's school is for other than (1) or (2) above, no premium refund will be made. Students or Scholars will be covered for the Policy term for which they are enrolled and for which premium has been paid.

Dependent coverage will not be effective prior to that of the Covered Student or extend beyond that of the Covered Student, except as specifically provided in the Policy. To avoid a lapse in coverage, premium must be received within the 31 day open enrollment period. It is the Covered Student's responsibility to make timely renewal payments to avoid a lapse in coverage. There will be no break or overlap in coverage for students re-enrolling who have maintained continuous coverage from the previous Policy Year.

***For specific College/University Plan effective and termination dates please go to www.studentinsurance.com and select your institution, utilizing the "Find your institution" pull down menu.**

2013-2014 STUDENT HEALTH INSURANCE PLAN PREMIUMS

DOMESTIC 2013-2014 Plan Premiums	Annual	Fall	Spring/Summer
UNDER 25 YEARS OF AGE			
Student Only	\$1,867.00	\$794.00	\$1,093.00
Spouse Only	\$4,246.00	\$1,793.00	\$2,473.00
Each Child	\$2,072.00	\$880.00	\$1,212.00
AGE 25-34			
Student Only	\$2,077.00	\$882.00	\$1,215.00
Spouse Only	\$4,246.00	\$1,793.00	\$2,473.00
Each Child	\$2,072.00	\$880.00	\$1,212.00
AGE 35-44			
Student Only	\$2,494.00	\$1,057.00	\$1,457.00
Spouse Only	\$4,468.00	\$1,887.00	\$2,601.00
Each Child	\$2,072.00	\$880.00	\$1,212.00
AGE 45+			
Student Only	\$2,845.00	\$1,205.00	\$1,660.00
Spouse Only	\$4,591.00	\$1,938.00	\$2,673.00
Each Child	\$2,072.00	\$880.00	\$1,212.00

Additional Payment Options available online at www.studentinsurance.com include: Monthly Credit Card Drafts. Included online are rates.

If enrolled in more than one of the available State University & Community College System of Tennessee insurance plans, benefits payable under all the plans combined will not exceed more than 100% of the Eligible Expense.

Optional Dental Coverage Available (upon initial enrollment only): \$179 per Covered Person

Optional Medical Evacuation and Repatriation of Remains Coverage Available: \$30 per Covered Person

TENNESSEE BOARD OF REGENTS DOMESTIC PLAN SUMMARY OF BENEFITS

	Preferred Provider	Out-of-Network
Deductible per Covered Person Per Policy Year	\$350 In-Network/\$700 Out-of-Network	
Aggregate Maximum Benefit per Injury or Sickness	\$500,000	
The Deductible will be waived and Eligible Expenses will be payable at 100% of R&C when services are rendered at the Student Health Center		
INPATIENT		
Room & Board except intensive care unit, limited to the average semi-private room rate	80% of Allowable Charges	60% of R&C Charges
Hospital Miscellaneous Expenses, includes 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.	80% of Allowable Charges	60% of R&C Charges
Surgeon's Fees, 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 only for the primary procedure performed.	80% of Allowable Charges	60% of R&C Charges
Assistant Surgeon	80% of Allowable Charges	60% of R&C Charges
Anesthesia	80% of Allowable Charges	60% of R&C Charges
Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN)	80% of Allowable Charges	60% of R&C Charges
Doctor's Visits, (Doctor other than a Doctor who performed surgery or administered anesthesia)(Limited to 1 visit per day)	80% of Allowable Charges	60% of R&C Charges
Pre-Admission Testing (Hospital confinement must occur within 14 days of the testing)	80% of Allowable Charges	60% of R&C Charges
Mental and Nervous Disorder/Alcoholism and Substance Abuse	80% of Allowable Charges	60% of R&C Charges
OUTPATIENT		
Surgeon's Fees, 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 only for the primary procedure performed.	80% of Allowable Charges	60% of R&C Charges
Day Surgery Miscellaneous, when scheduled surgery is performed in a Hospital or outpatient facility, 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).	80% of Allowable Charges	60% of R&C Charges
Anesthesia	80% of Allowable Charges	60% of R&C Charges

TENNESSEE BOARD OF REGENTS DOMESTIC PLAN SUMMARY OF BENEFITS

OUTPATIENT Continued...	Preferred Provider	Out-of-Network
Assistant Surgeon	80% of Allowable Charges	60% of R&C Charges
Doctor's Visits, benefits are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy. Includes injections when administered in the Doctor's office.	80% of Allowable Charges	60% of R&C Charges
Physiotherapy	80% of Allowable Charges	60% of R&C Charges
Hospital Emergency Room Expense, for use of emergency room, operating room, laboratory and x-ray examinations, and supplies	80% of Allowable Charges after a \$250 copay per visit (in addition to deductible) (copay waived if admitted as an inpatient)	60% of R&C Charges after a \$250 copay per visit (in addition to deductible) (copay waived if admitted as an inpatient)
Diagnostic X-Ray and Laboratory, CAT Scan/MRI	80% of Allowable Charges	60% of R&C Charges
Radiation and Chemotherapy	80% of Allowable Charges	60% of R&C Charges
Diagnostic Services and Medical Procedures performed by a Doctor (other than Doctor's visits, physiotherapy, x-rays and lab procedures).	80% of Allowable Charges	60% of R&C Charges
Prescribed Medicines Expense*. Benefits include all FDA-approved birth control methods. *Must pay full amount charged for covered prescriptions at the time of purchase and file for reimbursement	100% after \$20 generic copay or \$40 brand name copay per prescription or refill. The copay will be waived for FDA-approved birth control. Prescription benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person's Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic.	
Urgent Care Expense	\$75 copay per visit (in addition to deductible)	
	80% Allowable Charge	60% of R&C Charges
Mental and Nervous Disorder/Alcoholism and Substance Abuse	80% of Allowable Charges	60% R&C Charges
ADDITIONAL PLAN BENEFITS		
Ambulance Services	80% of Allowable Charges	80% of R&C Charges
Orthopedic Braces & Appliances	80% of Allowable Charges	80% of R&C Charges
Consultant Doctor Fees	80% of Allowable Charges	60% of R&C Charges
Dental Treatment (Injury only): \$100 Maximum per tooth/ \$1,000 Maximum per Injury	100% of Allowable Charges	100% R&C Charges
Maternity & Complications of Pregnancy	Paid as any other Sickness	
Needlestick & Splatter Expense (due to academic related exposure only):	80% Allowable Charge	60% of R&C Charges
Routine Screening for STD	80% Allowable Charge	60% of R&C Charges

Preventive Services up to an aggregate maximum of \$500,000 per Policy Year. Please go to www.studentinsurance.com to view a list of Preventive Services (as specified by the Patient Protection and Affordable Care Act (PPACA)).

- For eligible preventative care expenses at the Student Health Center, Eligible Expenses will be paid at 100% with no cost sharing.
- If the Student Health Center offers a service, but services are rendered outside the Student Health Center, Eligible Expenses will be paid the same as Sickness, subject to deductibles and copays.
- If the Student Health Center does not offer a preventative care service, and services are rendered outside the Student Health Center, benefits will be paid In-Network at 100% with no cost sharing or Out-of-Network Eligible Expenses will be paid the same as Sickness subject to deductibles and copays.

STATE MANDATED BENEFITS

This Plan covers all applicable state mandated benefits. Please see the Policy on file with the College for details.

OPTIONAL PLAN BENEFITS

OPTIONAL MEDICAL EVACUATION AND REPATRIATION OF REMAINS (additional premium required): (Pre-Authorization required: 1-888-722-1668) Medical Evacuation: \$10,000 maximum (when the Covered Person is Hospitalized for at least 5 consecutive days); Repatriation of Remains: \$10,000 maximum

OPTIONAL DENTAL TREATMENT EXPENSE (NON-INJURY)

If elected by the Covered Person during initial enrollment and the appropriate premium is paid, the Company will pay the Covered Percentage of eligible dental expenses incurred in excess of the \$50 dental treatment deductible up to an aggregate maximum of \$500 per Policy Year. Eligible dental expenses include preventive services; diagnostic services; and primary services.

Covered Percentage:

- For Diagnostic and Preventive Services: 100% of R&C Charges
- For Primary Services: 80% of R&C Charges

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. See the Policy on file with the Policyholder for details, including frequency and age limitations.

STUDENT HEALTH INSURANCE PLAN EXCLUSIONS

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 this Plan. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by this Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by this Policyholder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such; radial keratotomy or laser surgery; 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. Vision examinations not related to prescription or fitting of lenses will be covered only when performed in connection with the diagnosis or treatment of Sickness or Injury. Eye refraction is not covered. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing apart from the disease process.
5. 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.
6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
8. 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.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. 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 and reconstructive surgery because of a congenital disease or anomaly of a covered dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
11. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins anti-toxins except as specifically provided in this Plan. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
12. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, illegal occupation, insurrection or civil commotion.

Plan Exclusions Continued...

13. for Elective Treatment or elective surgery or voluntary or elective abortions unless otherwise provided in this Plan. This exclusion does not apply to non-elective abortion which is defined as a spontaneous termination of pregnancy which occurs during a period of gestation in which: (a) a viable birth is not possible; or (b) the life and health of the mother is in danger.
14. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
15. for any services rendered by a Covered Person's immediate family member.
16. for any treatment, service or supply which is not Medically Necessary.
17. 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.
18. for treatment of mental and nervous conditions except as specifically provided in this Plan.
19. for the treatment of alcoholism or substance abuse except as specifically provided in this Plan.
20. for Injury or Sickness caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage of or for the purpose as prescribed by the Covered Person's Doctor.
21. for surgery and/or treatment of: acupuncture; gynecomastia; allergy, including allergy testing and anti-toxins except prescription medications and injections; breast implants; or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions; deviated nasal septum, including submucuous resection and/or other surgical correction thereof; fertility tests; infertility(male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; learning disabilities, except as may be required by Public Chapter 894; attention deficit disorder, except as may be required by Public Chapter 894; premarital examinations; sexual reassignment surgery and related therapy; sleep disorders, including supplies, treatment and testing thereof; vasectomy; alopecia; and weight reduction.
22. for routine physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in this Plan. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
23. for patient controlled analgesia (PCA).
24. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted conception, elective sterilization or its reversal except as specifically provided, artificial insemination or in vitro fertilization.
25. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, club, professional and semi-professional sports activity, including travel to and from the activity and practice; hang gliding; parasailing; sky diving; glider flying; sail planing; parachuting; or any other hazardous sport or hobby.
26. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
27. for Injury resulting from fighting, except in self-defense.
28. for treatment of obesity, except resulting from diabetes, regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs; prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complication resulting from weight loss treatments or procedures.
29. for eye surgery such as radial keratotomy when the primary purpose is to correct myopia (near-sightedness), hyperopia (far-sightedness) or astigmatism (blurring).
30. for breast reconstruction and implantation or removal of breast prostheses unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.
31. for the services of an assistant surgeon except as specifically provided under this Plan.
32. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
33. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
34. for congenital conditions, except as required for newborn infants; genetic and/or hereditary defects.

STUDENT HEALTH INSURANCE PLAN DEFINITIONS

"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.

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

Plan Definitions Continued...

"Covered Person" means a Covered Student while coverage under this Plan is in effect and those dependents with respect to whom a Covered Student is insured.

"Covered Student" means a student of this Policyholder who is insured under this Plan.

"Doctor" 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.

"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; breast reduction unless as a result of mastectomy; sexual reassignment surgery; treatment for weight reduction; botox injections; treatment of infertility and routine physical examinations.

"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) is incurred while this Plan 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 Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:

- (a) the Covered Person's life could be in serious jeopardy;
- (b) bodily functions would be seriously impaired; or
- (c) a body organ or part would be seriously damaged; or
- (d) serious disfigurement; or
- (e) serious jeopardy to the health of the fetus.

"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.

"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; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) 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.

Plan Definitions Continued...

"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 or treatment; or
- (d) it is Experimental/Investigational or for research purposes; or
- (e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
- (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
- (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative 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.

"Pre-Existing Condition" means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 6 months prior to the Covered Person's effective date of coverage under this Plan or a pregnancy existing on the Covered Person's effective date of Coverage under this Plan.

"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:

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.

"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.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

CLAIMS PROCEDURES

1. **Written Notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible.** To submit the written claim form go to www.studentinsurance.com, log into your account and click on 'student options'. The claim form can be submitted online electronically.
 2. **In the event that a PPO Provider submits the Covered Person's claim(s), please be sure that the Provider photocopies the Covered Person's insurance card.**
 3. The Covered Person should retain one copy of all claims information submitted for his or her records.
- PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (Hospital, Doctor and others), UNLESS A PAID RECEIPT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

EXTENSION OF BENEFITS

If the Covered Person is confined to a Hospital on the date his or her coverage terminates as a result of Sickness or Injury for which benefits were payable prior to the date his or her coverage terminated, benefits will be payable for the Eligible Expenses incurred until the earliest of: (1) the end of Sickness or Injury; (2) the end of the 90 day period following the date his or her 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.

PRE-EXISTING CONDITIONS

Pre-existing Conditions are not covered for the first 12 months following a Covered Person's effective date of coverage under this Plan. This limitation will not apply if: (a) the Covered Person has been covered under the Policyholder's prior Policy for more than 12 consecutive months; or (b) the individual seeking coverage under this Plan has an aggregate of 12 months of creditable coverage and becomes eligible and applies for coverage under this Plan within 63 days of termination of prior creditable coverage. Credit will be given for the time the individual was covered under the prior creditable coverage; and becomes eligible and applies for coverage under this Plan within 63 days of termination of prior creditable coverage. Credit will be given for the time the individual was covered under the prior creditable coverage; and (1) the individual's most recent prior creditable coverage was under an employer group plan; and (2) the individual is not eligible for coverage under any other group health plan, Medicare or Medicaid; and (3) the individual does not have other health insurance.

PPO PROVIDERS

Covered Persons may choose to be treated within or outside of the First Health PPO Network. Reimbursement rates will vary according to the source of care as described under the Plan Summary of Medical Expense Benefits herein. Assignment of a Network Provider does not guarantee eligibility or right to student health benefits. It is the Covered Person's responsibility to verify that a provider is a Participating Provider prior to services being rendered. 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. When treatment or care is received at a PPO Hospital and, while confined, covered services are rendered by a Doctor or other health care professional not in the PPO network, benefits for Eligible Expenses are payable at the PPO level. 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 the facility to which the Covered Person is referred is also a PPO provider. For more information and/or a list of approved PPO providers, visit www.studentinsurance.com or call 1-888-722-1668.

COORDINATION OF BENEFITS PROVISION

The Company will coordinate benefits with other health insurance carriers when duplicate coverage exists. Total payment from this coverage and other health insurance coverages under which the Covered Person is enrolled shall not exceed 100% of the Eligible Expenses.

TRAVEL GUARD

DESCRIPTION OF TRAVEL ASSIST AND STUDENT ASSIST SERVICES

A benefit of your Student Insurance

Procedures on How to Access Travel Guard and Student Assist Services 24-Hour Assistance Call Center How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.
- Outside the US and Canada:
 - Request an international operator.
 - Ask the international operator to connect to an AT&T operator.
 - Request the AT&T operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 1-262-364-2203.

When to Contact Travel Guard:

- Before you incur expenses.
- If you are 100+ miles from home and require medical assistance or have a medical emergency.
- If you are 100+ miles from home and need assistance with a non-medical situation such as lost luggage, lost documents, legal help, etc.

Travel Guard is available

24-hours-a-day/7-days-a-week/ 365-days-a-year Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home. The Travel Guard Medical Staff consists of full-time, onsite Registered Nurses and Emergency Physicians who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a physician has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide Travel Guard when you call:

- Advise Travel Guard your TPA is AIG Property Casualty Claims, Inc., in South Carolina.
- Provide your Policy Number or School Name
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

DESCRIPTION OF SERVICES

General Information: Services listed below include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency, exchange rates, local Bank/Government holidays, and by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

- Visa & Immunization
- Weather & Exchange Rates

Technical: Services listed below include assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

- Legal Referral
- Lost/Stolen Luggage Information
- Claims-related Assistance & Personal Effects Assistance
- Lost Document Assistance & Cash Transfer Assistance
- Embassy/Consulate
- Telephone Interpretation
- Enroute Travel Assistance

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network providers and often include postcase payment/billing coordination on the traveler's behalf. These services include physician/dental/Hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains and insurance claims coordination.

Medical Assistance:

- Medical Referral
- In-patient Assistance
- Out-patient Assistance

Medical Transport:

- Evacuation
- Repatriation of Remains

REPATRIATION OF REMAINS AND MEDICAL EVACUATION

(Benefits for Repatriation of Remains and Medical Evacuation are provided by National Union Fire Insurance Company of Pittsburgh, Pa.)

COMBINED MAXIMUM LIMIT OF \$20,000

REPATRIATION OF REMAINS

In the event an Injury or emergency Sickness causes your death while you are outside your home country, the plan will reimburse Eligible Expenses reasonably incurred for preparation and transportation of the body remains.

MEDICAL EVACUATION

The plan will pay for evacuation to the nearest adequate medical facility following a covered Injury or emergency Sickness if you are outside your home country and a Doctor determines that adequate medical treatment is not locally available.

(Benefits will be considered only after the Covered Person has been hospitalized for a least 5 consecutive days.)

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions.

STUDENT ASSIST SERVICES

- Concierge Services: You receive the comfort, care, and attention of Travel Guard's Personal Assistance Coordinators available 24/7 to respond to virtually any request – large or small.
- Personal Security Assistance: You can feel safe and secure with Travel Guard's Personal Security Assistance at home or while traveling. To activate personal security services, please visit www.studentinsurance.com and log into your secure online account. For more details visit the AIG Property Casualty Claims, Inc., website at www.studentinsurance.com.



CLAIMS ADDRESS:

AIG, Educational Markets Mail Center
P.O. Box 26050
Overland Park, KS 66225

CLAIMS QUESTIONS:

AIG, Educational Markets
Toll Free: 1-888-722-1668

STUDENT HEALTH INSURANCE

Website: www.studentinsurance.com
E-mail: tbr@studentinsurance.com

ONLINE SERVICES

Go online at www.studentinsurance.com

Search for your Institution

On this secure site you can:

- Enroll
- Print ID Card
- Enroll Dependents
- Search for Providers and Hospitals
- Request a Certificate of Creditable Coverage
 - View a Summary of Benefits
 - View claims information / EOB's
 - Update your account information
 - Search for Providers and Hospitals
- View questions and answers about your insurance

The Policy is non-renewable one year term insurance. Similar coverage may be purchased for the following academic year. It is the Covered Student's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.

IMPORTANT INFORMATION

This brochure is a general summary of the insurance. This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-TN. The Policy on file at the College/University may contain definitions, reductions, limitations, exclusions and termination provisions not included in this brochure. 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. This Plan also covers Mandated Benefits as required by the State of Tennessee. Insurance and services provided by member companies of American International Group, Inc. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.