College of Charleston
(“the Policyholder”)

2015 – 2016
International Student Health Insurance Plan

Administrator Policy Number: CHH052126
Underwriter Reference Number: CAS9149460

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

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

This brochure is a general summary of the coverage under Policy Series S30749NUFIC-PPO-SC (Rev. 1-15). The Policy on file at the College contains all of the provisions, exclusions, limitations, definitions, and qualifications of your Plan benefits. If any discrepancy exists between this brochure and the Policy, the Policy will govern. The Plan also covers applicable Mandated Benefits as required by the State of South Carolina. For additional information, please visit our website at www.AIG.com.

Please note that information included in this DRAFT brochure is subject to change subsequent to regulatory approval of the policy by the South Carolina Department of Insurance.
ELIGIBILITY

The following types of students attending the College of Charleston ("the College") will be automatically enrolled in the College of Charleston International Student Health Insurance Plan ("the Plan") and the premium for the insurance will be added to their tuition bill each semester along with tuition and fees, unless a waiver of coverage is submitted online at http://studentinsurance.com/Apps/Schools/Default.aspx?ID=573 showing proof of alternate insurance that meets the College’s requirements before the waiver deadline:

1. Students who are enrolled in the College of Charleston International Student Program; and
2. Students who are enrolled in the College of Charleston Intensive English Student Program.

Waivers of coverage will only be accepted online and no waivers will be accepted after the waiver deadline date. The deadline dates for submitting waivers are as follows:

**International Student Program:**
- Fall Coverage Term: September 15, 2015
- Spring/Summer Coverage Term: February 1, 2016
- Summer Coverage Term: June 16, 2016

**Intensive English Program:**
- Fall I Coverage Term: September 15, 2015
- Fall II Coverage Term: November 26, 2015
- Spring I Coverage Term: February 7, 2016
- Spring II Coverage Term: April 10, 2016
- Summer Coverage Term: June 4, 2016

A waiver of coverage must be submitted for each coverage term.

Note: Eligible students who do not wish to waive coverage under the Plan may choose to initiate the enrollment process at:


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 coverage, please email proof of ineligibility to qualifier@studentinsurance.com.

An eligible student must actively attend classes at the College 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. 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 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.

Eligible students who are enrolled in the Plan may also enroll their eligible Dependents (see definition of Dependent). 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. A Covered Student may enroll his or her Dependents by completing the enrollment process and paying the required premium at http://studentinsurance.com/Apps/Schools/Default.aspx?ID=573 by the waiver deadline dates outlined above. Dependents must be enrolled in the same coverage term in which the Covered Student is enrolled.

EFFECTIVE AND TERMINATION DATES

The Policy on file at the College becomes effective at 12:01 a.m. on August 15, 2015 and terminates at 11:59 p.m. on August 14, 2016. 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 Plan 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 term 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 covered Dependent’s coverage shall take effect on the later the following dates: (1) the date the coverage for the Covered Student becomes effective; or (2) the date the Dependent is enrolled for coverage, provided premium is paid when due.

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

(a) the date the Plan terminates;
(b) the last day for which any required premium has been paid; or
(c) the date on which the Covered Student withdraws from the school:
1. because of entering the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made); or
2. 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 College is for other than (1) or (2) above, no premium refund will be made. Students will be covered for the Plan term for which they are enrolled and for which premium has been paid.

NOTE: Except as specifically provided in the Policy, Dependent coverage expires concurrently with that of the Covered Student.

**PPO PROVIDERS**

For services rendered in the State of South Carolina, Covered Persons insured under the Plan may choose to be treated within or outside of the Medcost PPO Network. For services rendered outside of the State of South Carolina, Covered Persons insured under the Plan 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 Schedule of Benefits. Assignment of a Network Provider does not guarantee eligibility or right to student health benefits. For treatment or care received at a Non-PPO provider because a PPO provider is not available, benefits for Eligible Expenses are payable at the PPO level.

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. 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.

If treatment or care is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

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


**COORDINATION OF BENEFITS PROVISION**

The Policy’s Coordination of Benefits provision will be used to determine a Covered Person’s benefits under the Plan if:
1. the person is insured for medical care benefits under the Plan and is also covered for these benefits under other plans; and
2. the benefits that would be paid by the Plan, without this provision plus the benefits that would be paid by the other plans, without a provision similar to this provision, would exceed allowed expenses.

### PLAN PREMIUMS

<table>
<thead>
<tr>
<th>PLAN PREMIUMS</th>
<th>Fall 8/15/2015-12/31/2015</th>
<th>Spring/Summer 1/1/2016-8/14/2016</th>
<th>Summer (new students to the College in the Summer Semester Only) 5/16/2016-8/14/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2015-2016 International Student Program</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>$650.00</td>
<td>$898.00</td>
<td>$403.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,126.00</td>
<td>$1,556.00</td>
<td>$698.00</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$809.00</td>
<td>$1,117.00</td>
<td>$501.00</td>
</tr>
<tr>
<td><strong>2015-2016 Intensive English Program</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall I 08/15/15 – 10/25/2015</td>
<td>Fall II 10/26/15 – 01/06/2016</td>
<td>Spring I 01/07/2016 – 03/09/2016</td>
<td>Spring II 03/10/2016 – 05/04/2016</td>
</tr>
<tr>
<td>Student</td>
<td>$323.00</td>
<td>$323.00</td>
<td>$258.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$559.00</td>
<td>$559.00</td>
<td>$447.00</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$402.00</td>
<td>$402.00</td>
<td>$321.00</td>
</tr>
</tbody>
</table>
## COLLEGE OF CHARLESTON INTERNATIONAL PLAN SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Aggregate Maximum Benefit per Policy Year per Covered Person</th>
<th>HEALTH CARE IN-NETWORK</th>
<th>HEALTH CARE OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per Policy Year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Covered Person</td>
<td>$150</td>
<td>$400</td>
</tr>
<tr>
<td>Per Family</td>
<td>3 times the Deductible per Covered Person</td>
<td>3 times the Deductible per Covered Person</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Covered Person</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Per Family</td>
<td>$7,500</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

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&C"); charges in excess of any specified maximum or charges incurred for any services not covered under the Plan.

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, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible medical Expense incurred by such Covered Student and his 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.

### INPATIENT

<table>
<thead>
<tr>
<th>Service Description</th>
<th>HEALTH CARE IN-NETWORK</th>
<th>HEALTH CARE OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Room and Board, limited to the average semi-private rate except if Intensive Care Unit</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Miscellaneous</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Pre-Admission Testing (Hospital Confinement must occur within 5 days of the testing)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: (a) rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Physiotherapy, occupational therapy, cardiac/pulmonary therapy during Hospital Confinement, limited to one visit per day.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Surgical Expense</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>In-Hospital Doctor’s Fees Expense</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Includes consultant during Hospital Confinement when required and approved by attending Doctor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Conditions Expense</td>
<td>Same as any other Sickness</td>
<td>Same as any other Sickness</td>
</tr>
<tr>
<td>Suicide, Attempted Suicide and Intentionally Inflicted Injury: Medically necessary inpatient services to treat medical emergencies resulting from such actions will be covered as an Emergency Medical Condition.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(Medical Evacuation benefits resulting from attempted suicide or intentionally inflicted Injury will be considered under the Medical Evacuation Expense benefit.) Definitive treatment of any underlying mental health causal factors shall be covered under the Mental and Nervous Disorders benefits.

<table>
<thead>
<tr>
<th>Alcoholism and Substance Abuse Expense</th>
<th>Same as any other Sickness</th>
<th>Same as any other Sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td><strong>HEALTH CARE</strong></td>
<td><strong>HEALTH CARE</strong></td>
</tr>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td></td>
</tr>
<tr>
<td>Surgical Expense</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery (Co-pay waived if the Covered Person is admitted to the Hospital as an inpatient)</td>
<td>80% of Allowable Charge after a $150 Co-pay per visit</td>
<td>80% of R&amp;C after a $150 Co-pay per visit</td>
</tr>
<tr>
<td>Preventive Services mandated by the Patient Protection and Affordable Care Act (Please go to <a href="http://www.studentinsurance.com/Schools/SC/coci/">www.studentinsurance.com/Schools/SC/coci/</a> to view a list of Preventive Services)</td>
<td>100% of Allowable Charge, not subject to Deductible, Co-pay Amounts, or coinsurance.</td>
<td>No benefit</td>
</tr>
<tr>
<td><strong>Allergy Testing</strong></td>
<td>Benefits include, but are not limited to, charges for the following: laboratory tests; Doctor's office visits, including visits to administer injections; prescribed medications for testing of the allergy, including equipment used in the administration of prescribed medication; and other Medically Necessary supplies and services. Such are Eligible Expenses and are payable as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Laboratory and X-Ray Examinations (not otherwise covered under Preventive Services)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>CAT Scan/MRI and/or PET Scan</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (no benefits will be payable for rental charges in excess of the purchase price) and Orthopedic Appliance</td>
<td>80% of Allowable Charge</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Orthopedic Braces and Appliances (benefits are payable only upon Doctor's written prescription)</td>
<td>80% of Allowable Charge</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Prosthetic Appliances and Devices</td>
<td>80% of Allowable Charge</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td><strong>Rehabilitative Services/Habilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Cardiac/Pulmonary</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dialysis and Filtration Procedures</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Intravenous Home Therapy</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Injections and/or Immunizations (not otherwise covered under</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>
### Preventive Services

- **Diagnostic Services and Medical Procedures** performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and lab procedures), including Sickle Cell Anemia Testing (not otherwise covered under Preventive Services)
  - 80% of Allowable Charge
  - 60% of R&C

### Out of Hospital Doctor’s Fees Expense, including infusion therapy.

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Coverage Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor (other than Specialist)</td>
<td>80% of Allowable Charge</td>
</tr>
<tr>
<td>Specialist</td>
<td>80% of Allowable Charge</td>
</tr>
<tr>
<td></td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

### Consultant’s Fees Expense

- 80% of Allowable Charge
- 60% of R&C

### Ambulance Expense

- 80% of Allowable Charge
- 80% of R&C

### Pediatric Dental Treatment Expense (for Covered Persons under age 19 only)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Basic Services</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Major Services</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50% of R&amp;C</td>
</tr>
</tbody>
</table>

### Dental Treatment Expense For Injury:

- Injury to Sound Natural Teeth: 80% of R&C, limited to $1,000 per Policy Year

### Prescribed Medicines Expense - Co-pay per prescription, limited to a 30 day supply.

- 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, plus the brand name Co-pay.

### Psychiatric Conditions Expense

- **Suicide, Attempted Suicide and Intentionally Inflicted Injury:** Medically necessary outpatient services to treat medical emergencies resulting from such actions will be covered as an Emergency Medical Condition. (Medical Evacuation benefits resulting from attempted suicide or intentionally inflicted Injury will be considered under the Medical Evacuation Expense benefit.) Definitive treatment of any underlying mental health causal factors shall be covered under the Mental and Nervous Disorders benefits.

### Alcoholism and Substance Abuse Expense

- Same as any other Sickness
**Pediatric Vision Care Expense** (for Covered Persons under age 19 only)

<table>
<thead>
<tr>
<th>Examination</th>
<th>100% of R&amp;C after a $15 Co-pay per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials</td>
<td>100% of R&amp;C after a $15 Co-pay per visit</td>
</tr>
<tr>
<td>Standard Plastic Lenses:</td>
<td>Maximum Amount:</td>
</tr>
<tr>
<td>Single vision</td>
<td>$150</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$150</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$150</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$150</td>
</tr>
<tr>
<td>Progressive</td>
<td>$150</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
</tr>
</tbody>
</table>

Benefits are limited to one examination, one pair of lenses, and one frame per Policy Year.

- **Home Health Care Expense**: 80% of Allowable Charge, limited to 60 visits per Policy Year
- **Hospice Care Expense**: 80% of Allowable Charge, 60% of R&C
- **Urgent Care Expense**: 80% of Allowable Charge after a $50 Co-pay per visit, 60% of R&C after a $50 Co-pay per visit
- **Skilled Nursing Facility**: 80% of Allowable Charge, 60% of R&C

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

**Maximum Amount: $5,000**

The Company will pay the benefit below for Injuries to a Covered Person: (a) caused by an Accident which happens while covered by the Plan; and (b) which directly, and from no other cause, result in any of the losses listed below within 180 days of the Accident that caused the Injury.

<table>
<thead>
<tr>
<th>Loss of</th>
<th>Percentage of Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both Hands or Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>The Sight of One Eye</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and Index Finger of Same Hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means the total, irrevocable loss of the entire sight in that eye. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Severance" means the complete separation and dismemberment of the part from the body.

If a Covered Person suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.

**REPATRIATION OF REMAINS AND MEDICAL EVACUATION COMBINED MAXIMUM LIMIT OF $1,000,000**

**REPATRIATION OF REMAINS**

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 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 Group, Inc. ("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. For assistance, please call 1-888-249-5692.
MEDICAL EVACUATION
The Company will pay 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. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for any 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. For assistance, please call 1-888-249-5692.

STATE MANDATED BENEFITS
This Plan also covers applicable Mandated Benefits as required by the State of South Carolina.

PLAN EXCLUSIONS AND LIMITATIONS
Notwithstanding any provision of the Plan to the contrary, if the Plan generally provides benefits for any type of Injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health condition), even if the medical condition is not diagnosed before the Injury.

The Plan 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 Essential Health Benefits 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 except as specifically provided; radial keratotomy or laser surgery. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids except as specifically provided.
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 scheduled airline maintaining regular published schedules on a regularly established route.
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 to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible; or (c) as specifically provided for in the Policy. It also shall not include breast reconstructive surgery after a mastectomy.
11. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
12. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins anti-toxins except as specifically provided in the Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
13. as a result of committing or attempting to commit an assault or felony or participation in a riot, or civil commotion.
14. for Elective Treatment or elective surgery; except as specifically provided in the Policy.
15. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
16. for any services rendered by a Covered Person’s Immediate Family Member.
17. for any treatment, service or supply which is not Medically Necessary.
18. for surgery and/or treatment of: acne; acupuncture; gynecomastia; biofeedback-type services; breast implants; or breast reduction unless Medically Necessary following a mastectomy; circumcision; deviated nasal septum, including submucuous resection and/or other surgical correction thereof except for purulent sinusitis; 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; nonmalignant warts, moles and lesions; premarital examinations; sexual reassignment surgery; vasectomy; alopecia. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.

19. for routine physical examinations, health examinations or preschool physical examinations. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.

20. for patient controlled analgesia (PCA).

21. for artificial insemination or in vitro fertilization.

22. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle); or bungee jumping.

23. for elective abortions.

24. for chiropractic care or treatment not related to the treatment of Injury or Sickness except as specifically provided.

25. 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; sporting events; racing or speed contests; hang gliding; parasailing; sky diving; glider flying; sail planing; parachuting.

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, services, drugs, device, procedures or supplies that are Experimental or Investigational.

29. for treatment, service or supply for which a charge would not have been made in the absence of 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.

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

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

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

“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
- 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 pre-eclampsia; 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 Plan.

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

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

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

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

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

“**Dependent**” means: (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.

The term “child” includes:

(a) a legally adopted child;

(b) a child who has been placed 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 Plan because he or she:
(a) was born out of wedlock;
(b) is not claimed as a dependent on the Covered Student’s or Spouse’s federal tax return;
(c) does not reside with the Covered Student or Spouse in the Plan’s service area.

The term "child" includes a child of the Covered Student or Spouse who is a non-custodial parent. In such case, the Company will:
(a) provide information to the custodial parent as may be necessary for the child to obtain benefits applicable to Covered Dependents under the Plan;
(b) permit the custodial parent or the health care provider, with the custodial parent’s approval, to submit claims for Eligible Expenses without the approval of the non-custodial parent; and
(c) make payments on claims directly to the custodial parent, health care provider or the social services district furnishing medical assistance to the child, whichever is applicable.

The term "child" also includes a child for whom the parent covered under the Plan is required to provide coverage by the South Carolina Division of Child Support Enforcement on behalf of the appropriate local social services district in compliance with a court order issued by a court of competent jurisdiction. In the event such is the case, such parent may apply to insure the child, if he or she is otherwise eligible for coverage, without regard to any enrollment requirements. Insurance will become effective for such child on the date the Company receives the request. If the parent is eligible for Dependent insurance under the Plan but fails to apply to insure the child in accordance with the court or administrative order, such child will become insured on the date the Company receives the written request to insure the child from the child’s other parent, the state agency administering the Medicaid program or the state agency administering the Child Support Enforcement program.

"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; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinuses; botox injections.

"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 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 medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(b) serious impairment to bodily functions; or
(c) serious dysfunction of any bodily organ or part.

"Emergency Services" means, with respect to an Emergency Medical Condition:
(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; (c) as a place for custodial or educational care; or (d) as an institution mainly rendering treatment services or services for: mental or nervous disorders. 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; and (c) 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.

“Intensive Care Unit” means a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.

“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.

“One Sickness” means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.
"Orthopedic Brace and Appliance" means a supportive device or appliance used to treat a Sickness or Injury.

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

"Policy Year" means the period of time measured from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

"Pre-Admission Testing" means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person’s condition in anticipation of a scheduled Hospital Confinement and required prior to surgery; a Hospital bed and operating room have been reserved before the tests are made; Hospital Confinement begins within 5 days after the tests; and the Covered Person is physically present for the tests. In the event pre-admission testing is ordered by the attending Doctor and the Hospital Confinement and/or surgery are subsequently canceled, benefits for pre-admission testing and services already performed will be covered and benefits will be payable under the Plan based on the available coverage.

"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" 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.

"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.

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

CLAIMS PROCEDURES

Please call 1-888-722-1668 for pre-notification of all Hospital Confinements and day surgery prior to admission.

1. Written notice of claim must be given to the Company within 50 days or as soon thereafter as 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 or mail claims to:
   AIG, Higher Education Mail Center
   PO Box 26050
   Overland Park, KS 66225

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.
PRE-NOTIFICATION RECOMMENDED

The Covered Person should report to the Company all non-emergency inpatient admissions to a Hospital, including length of stay, and all surgical procedures performed in an outpatient facility or ambulatory surgical center that require general anesthesia. To report an inpatient or outpatient service call 1-888-722-1668. Pre-Notification is not a guarantee that benefits will be paid.

CERTIFICATE OF CREDIBLABLE COVERAGE

The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Plan is terminated. In addition, Certificates 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 Plan. Such issuance will occur within a reasonable time.

In order to obtain a Certificate of Creditable Coverage please contact AIG, Higher Education Markets, at 1-888-722-1668 or log into your secure online account and request your certificate. The Certificate of Coverage will then be made available through the Covered Student’s secure online account.

EXTENSION OF BENEFITS

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

If a Covered Person is undergoing outpatient treatment for an Emergency Medical Condition on the termination date, Eligible Expenses shall include charges incurred for that Emergency Medical Condition, but only while they are incurred during the 30 day period following such termination of insurance, subject to the applicable Maximum Amounts of the Policy.

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.

SUBROGATION

In the event any payments for benefits provided to a Covered Person are because of an Injury or Sickness caused by a Third Party’s wrongful act or negligence, the Company, to the extent of that payment, will be subrogated to any recovery or right of recovery the Covered Person has against that Third Party, provided: (a) the Covered Person is entitled to payment for Hospital, surgical or medical services as the result of a Third Party settlement or court judgment; and (b) such settlement or judgment specified an amount or portion of payment that represents payment for such benefits; and (c) the Company has paid benefits to the Covered Person under this Policy for the same services or benefits covered by the settlement or judgment.

The Covered Person agrees to make a decision on pursuing a claim against a Third Party within 30 days of the date the Company requires that the Covered Person provide Notice of Claim for the Injury or Sickness for which benefits under this Policy are sought and to notify the Company of his or her decision within such 30 day period.

If the South Carolina Director of Insurance, upon petition by the Covered Person, determines that the exercise of subrogation by the Company is inequitable and commits an injustice to the Covered Person, subrogation under this provision will not be allowed. This determination by the South Carolina Director of Insurance or his designee may be appealed to the Administrative Law Judge Division, as provided by law in accordance with §38-71-190.

In the event the Covered Person decides not to pursue payment of claim against such Third Party, the Covered Person: (a) authorizes the Company to pursue, sue, compromise or settle any such payment of claim in the name of the Covered Person; (b) authorizes the Company to execute any and all documents necessary; and (c) agrees to cooperate fully with the Company in the prosecution of any such payment of claim.

If the Company exercises its rights under this provision, it will recover no more than the amount paid under this Policy for such benefits. The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above. Attorney’s fees and cost will be paid by the Company from any amounts recovered on behalf of the Covered Person.

“Subrogation” means the Company’s right to recover any benefit payments made under this plan: (a) because of an Injury or Sickness to a Covered Person caused by a Third Party’s wrongful act or negligence; and (b) which become recoverable from the Third Party or the Third party’s insurer.

The Company’s right of subrogation will not be enforced until the Covered Person has been made whole, as determined by a court of law, as a result of Injury or Sickness.

“Third Party” means any person or organization other than the Company, this Policyholder or the Covered Person. This provision will not apply if it is prohibited by law.
CLAIM ADDRESS

AIG, Higher Education Mail Center
P.O. Box 26050
Overland Park, KS 6625

CLAIMS QUESTIONS

AIG, Higher Education
Toll Free: 1-888-722-1668

STUDENT HEALTH INSURANCE

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

ONLINE SERVICES

(A secure site for all of your insurance needs)

Go online at www.studentinsurance.com

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On this secure site you can:
• Enroll
• Waive Coverage
• Print ID Card
• Enroll Dependents
• Update your personal information
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• Take a Survey
• Join Red Alerts When Traveling
• Access the Mobile Experience

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