



Wayne State University

("the Policyholder")

Student Health Insurance Plan For International Students

2013 - 2014

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

Accident and Sickness Plan:
Administrator Policy Number: CHH8036294
Underwriter Reference Number: CAS9495383

Keep this brochure as a general summary of the insurance

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 1-888-622-6001. 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.

This brochure is only a brief description of the coverage available under policy series S30749NUFIC-PPO-MI. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Master Policy on file at the University. If any discrepancy exists between the contents of this brochure and the Policy, the Policy will govern in all cases.

UNIVERSITY HEALTH SERVICES

The Campus Health Center is the University's on-campus health facility. Staffed by adult and family nurse practitioners and others, it is open: Monday-Friday, 9:00 a.m. to 6:00 p.m. For more information, call the Campus Health Center at (313) 577-5041. In the event of an emergency, call 911 or the Campus Police at (313) 577-2222. Please inform them that you are an International Student or Scholar.

ELIGIBILITY

All registered international students and scholars taking credit hours at Wayne State University are eligible for coverage under the Wayne State University Student Health Insurance Plan (the "Plan"). Eligible international students and scholars are required to enroll in this Plan by the appropriate enrollment deadline listed below. To enroll, eligible students and scholars should go to <http://www.studentinsurance.com/schools/MI/Wayne/>, select Wayne State University from the drop-down menu on the left hand side and follow the instructions; or if assistance is necessary, the student or scholar should contact the OISS Office.

Enrollment Period	Enrollment Deadline
Annual	10/16/13
Fall.....	10/16/13
Winter	01/25/14
Summer	07/03/14
Winter/Spring/Summer	01/25/14
The annual cost for a student or scholar to	

enroll in the Plan is:

Student under the age of 30: \$1,371

Student 30 and older: \$2,019

An eligible student or scholar must actively attend classes at this University for at least the first 30 days of the period for which he or she is enrolled. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student or scholar status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

An eligible students or scholar may also enroll his or her eligible dependents. An eligible dependent is: (a) the Covered Student's or Scholar's spouse residing with the Covered Student or Scholar; and (b) the Covered Student's or Scholar's or spouse's child until the date such child attains age 26. A dependent may become eligible for coverage under the Plan only when the student or scholar becomes eligible; or within 31 days of marriage, birth or adoption.

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on August 1, 2013 and terminates at 11:59 p.m. on July 31, 2014.

The coverage of an eligible student or scholar who enrolls for coverage under the Policy 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 or Scholar's coverage is received by the Company; (3) the date the Policyholder's term of coverage begins; or (4) the date the student or scholar 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 or Scholar becomes effective; or (2) the date the dependent is enrolled for coverage, provided premium is paid when due.

Insurance for a Covered Student or Scholar 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; or (c) the date on which the Covered Student or Scholar withdraws from the University 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 30 days of leaving the University); or (2) withdrawal from the University during the first 30 days of the period for which enrollment was made.

If withdrawal from the University 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.

Except as specifically provided in the Policy, insurance for a Covered Student's or Scholar's dependent will end when insurance for the Covered Student or Scholar ends.

It is the Covered Student's responsibility to assure timely renewal payments to avoid a lapse in coverage. A lapse in coverage will subject claims to the pre-existing condition limitation.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under the Plan is "Creditable Coverage" under Federal Law. When coverage terminates, the Covered Person can request a Certificate of Coverage within 24 months after cessation of coverage under the

Policy that is evidence of coverage under the Plan. The Covered Person may need such a certificate if he she becomes covered under a group health plan or other health plan within 63 days after the coverage under the Plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions the Covered Person had before enrolling, this Certificate may be used to reduce or eliminate those exclusions or limitations.

In order to obtain a Certificate of Creditable Coverage, the Covered Student or Scholar should contact AIG, Educational Markets, at 1-888-722-1668. The Certificate of Coverage will be placed in the Covered Student's or Scholar's online account when he or she calls.

NON-DUPLICATION OF COVERAGE

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

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 30 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.

STATE MANDATED BENEFITS

The State of Michigan mandates coverage for the following benefits: Treatment of Alcoholism and Substance Abuse; Diabetes Treatment and Prevention; Reconstructive Breast Surgery following a Mastectomy; Breast

Cancer Screening; Autism Spectrum Disorder; Antineoplastic Therapy; Off-Label Drugs; and any other applicable mandated benefits as required by the State of Michigan.

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).

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

“Covered Person” means a Covered Student or Scholar while coverage under the Policy is in effect and those dependents with respect to whom a Covered Student or Scholar is insured.

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

“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; submucous resection and/or other surgical correction for deviated nasal septum; treatment for weight reduction; learning disabilities; botox injections; treatment of infertility and routine physical examinations.

“Eligible Expense” means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury; (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) with respect to the Preferred Provider, is the Allowable Charge; (d) is the negotiated rate, if any; and (e) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

“Emergency Medical Condition” means the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the Covered Person's health or to a pregnancy in the case of a pregnant Covered Person, serious impairment to bodily functions, or 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 in the definition of Emergency Medical Condition.

“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) 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.

“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 the Policy or a pregnancy existing on the Covered Person’s effective date of Coverage under the Policy.

“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.

EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment, or dental x-rays except as provided elsewhere in the Policy. This exclusion does not apply to Preventive 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; hearing aids or prescriptions or examinations for such except as required for repair caused by a covered Injury. Eye refraction is not covered. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery. "Cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part 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.
10. 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.
11. 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.
12. for Elective Treatment or elective surgery.

SCHEDULE OF BENEFITS

Aggregate Maximum Benefit per Policy Year-\$500,000

Deductible \$150 per Policy Year per Covered Person. Referral Requirement recommended (see page 18). When the Covered Person's share of the Eligible Expenses reaches a \$5,000 Out-of-Pocket Limit per Policy Year, the Company will pay 100% of Eligible Expenses subject to applicable maximums. Co-payments and amounts above applicable maximums do not apply toward the Out-of-Pocket Limit. The covered percentage applicable to all Eligible Expenses incurred for services rendered at the Student Health Center for the care and/or treatment of Injury or Sickness shall be 100% of the Eligible Expenses. For all other providers, the covered percentage for the Eligible Expenses incurred for care and treatment of Injury or Sickness shall be as shown below.

ELIGIBLE MEDICAL SERVICES	IN-NETWORK	NON-NETWORK
INPATIENT BENEFITS		
Room and Board and general nursing care (except ICU, limited to the average semi-private room rate)	80% of Allowable Charges	60% of R&C Charges
Hospitalization Expense Benefit Miscellaneous Hospital Expense (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
Pre-Admission Testing	80% of Allowable Charges	60% of R&C Charges
Physiotherapy	80% of Allowable Charges	60% of R&C Charges
Surgical Services (Doctor's Charges)	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
Doctor / Consultant Visits	80% of Allowable Charges	60% of R&C Charges
Mental or Nervous Disorders & Alcohol or Substance Abuse	Same as any other Sickness	Same as any other Sickness
OUTPATIENT BENEFITS		
Day Surgery Facility/Miscellaneous when scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines)	80% of Allowable Charges	60% of R&C Charges
Surgical Services (Doctor's Charges)	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
Doctor's Fees Expense (Includes routine physical examination; and TB skin tests and TSpot blood test when administered in the Doctor's office.)	80% of Allowable Charges	60% of R&C Charges
Physiotherapy - Benefits are payable for a condition that required surgery or Hospital confinement: (1) within 30 days immediately preceding such physiotherapy; or (2) within 30 days immediately following the attending Doctor's release for rehabilitation.	80% of Allowable Charges	60% of R&C Charges
Hospital Emergency Room Expense (use of emergency room and supplies)	80% of Allowable Charges	80% of R&C Charges
Laboratory and X-Ray Examinations, CAT Scan/MRI	80% of Allowable Charges	60% of R&C Charges
Radiation Therapy and Chemotherapy	80% of Allowable Charges	60% of R&C Charges
Mental or Nervous Disorders	Same as any other Sickness	Same as any other Sickness
Preventive Services Benefit includes preventive services such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services, log onto: www.hhs.gov/healthcare/prevention/index.html	100% of Allowable Charges (not subject to deductible or co-payment amounts)	60% of R&C Charges
Consultant's Fees Expense	80% of Eligible Expenses	60% of R&C Charges
Alcohol or Substance Abuse -Outpatient and Intermediate Care Facility	Same as any other Sickness	Same as any other Sickness
Outpatient Prescription Drugs The Preferred Providers for prescriptions are through Informed Rx of the Catamaran Corporation. For the complete listing is providers, go to http://www.studentinsurance.com/Schools/MI/Wayne/ . Benefits include prescribed FDA-approved birth control methods.	100% of Eligible Expenses subject to the following co-payment amount per 30 day supply: Generic: \$25 Brand Name: \$50 The co-payment amount will be waived for prescribed FDA-approved birth control methods.	
Maternity Care	Same as any other Sickness	Same as any other Sickness
Immunization Expenses —Eligible Expenses do not include a Doctor's office visit in connection with immunization or testing for tuberculosis	80% of Allowable Charges	60% of R&C Charges
OTHER SERVICES		
Ambulance Service	80% of Eligible Expenses	80% of Eligible Expenses
Durable Medical Equipment / Braces and Appliances (only upon a Doctor's written prescription)	80% of Allowable Charges	60% of R&C Charges
Dental (Injury to sound, natural teeth)	80% of Allowable Charges	60% of R&C Charges
Dental Treatment up to \$500 maximum per policy year, subject to a \$25 deductible per policy year:		

13. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

14. for any services rendered by a Covered Person's immediate family member.

15. for any treatment, service or supply which is not Medically Necessary.

16. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.

17. for treatment of temporomandibular joint dysfunction.

18. for loss due to voluntary use of any drug, narcotic or controlled substance, unless prescribed by a Doctor.

19. for surgery and/or treatment of: acne; biofeed-back-type services; corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof unless due to Injury occurring while coverage is in force; 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 and related therapy; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including supplies, treatment and testing thereof; vasectomy; and weight reduction. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.

20. 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 the Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.

21. as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place, except in a Driver's Education program.

22. 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.

23. for organ, tissue and cell transplants.

24. for voluntary or elective abortions.

25. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, club, professional and semi-professional sports; scuba diving; hang gliding; 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 treatment, services, drugs, device, procedures or supplies that are experimental or investigational.

28. within the Covered Person's home country of domicile with respect to an international Covered Person.

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

In addition to Exclusions and Limitations, the Policy does not cover any medical treatment for Pre-existing Conditions as defined. This limitation does not apply:

(a) to the first \$3,000 of Eligible Expenses incurred during the first 6 months of coverage; or

(b) if the Covered Person has been covered under the Policy for more than 6 consecutive months; or

(c) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. Credit will be given for the time the individual was covered under prior Creditable Coverage; and (1) if the individual's most recent prior Creditable Coverage was under an employer group health plan; and (2) the individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered him or her.

The Pre-existing Conditions limitation does not apply to:

(a) a newborn dependent child; or

(b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while

covered under the Policy, and the child has not attained 18 years of age; or
 (c) a Covered Person under age nineteen (19).

CREDIT FOR PRIOR COVERAGE: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under the Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

- (a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (b) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395a through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;
- (c) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;
- (d) Chapter 55 of Title 10, United States Code;
- (e) a medical care program of the Indian Health Service or of a tribal organization;
- (f) a health plan offered under chapter 89 of Title 5, United States Code;

- (g) a public health plan*; or
- (h) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
- (i) a high risk pool in any state.

*A public health plan is defined as any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverages to individuals who are enrolled in the plan.

ACCIDENTAL DEATH AND DISMEMBERMENT

Maximum Amount: \$10,000

The Company will pay the benefit below for Injuries to a Covered Person: (a) caused by an Accident which happens while covered by the Policy; 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.

For Loss of	Percentage of Maximum Amount
Life.....	100%
Both Hands or Both Feet.....	100%
Sight of Both Eyes.....	100%
One Hand and One Foot.....	100%
One Hand and the Sight of One Eye.....	100%
One Foot and the Sight of One Eye.....	100%
One Hand or One Foot.....	50%
The Sight of One Eye.....	50%
Thumb and Index Finger of Same Hand.....	25%

"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.

STUDENT HEALTH CENTER REFERRAL

A referral from the Student Health Center is recommended before benefits are payable. This provision does not apply if: (a) the Student Health Center is

closed; (b) medical care is obtained by a student or scholar who is not eligible to use the Student Health Center; or (c) Emergency Medical Condition.

The Deductible will be waived when: (1) services are provided at the Student Health Center; or (2) a referral is made by a Student Health Center Doctor. The applicable Deductible shall apply to all of the exceptions to the referral requirement shown above.

PREFERRED PROVIDER ORGANIZATION

Preferred Provider Organization: Cofinity
Toll-Free Telephone Number: 800-226-5116
Cofinity Website: www.cofinity.com

In an effort to control insurance medical costs and enhance payment, this Plan has implemented a Preferred Provider Organization (PPO) of Hospitals, facilities and Doctors who have contracted to provide service at a negotiated rate to Covered Persons eligible for benefits. The PPO for Wayne State University is Cofinity.

If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not guarantee that all providers at the Hospital are participating providers. In addition, if a Covered Person is referred by a participating provider to another facility or provider, it does not mean that the provider or facility to which the Covered Person is referred is also a participating provider. It is the Covered Person's responsibility to verify that the provider is part of the PPO. A list of providers in the Cofinity Network is also available for review via the "Preferred Provider Lookup" that can be accessed at <http://www.studentinsurance.com/Schools/MI/Wayne/>. 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.

EXCESS COVERAGE LIMITATION

If a Covered Person incurs Eligible Expenses for any of the services on the Schedule of Benefits, the Company will pay the Eligible Expenses incurred, subject to the deductible amount and covered per-

centage (if any), that are in excess of expenses payable by any other health care plan, regardless of any Coordination of Benefits provision contained in such health care plan.

CONTINUOUS COVERAGE

Continuously insured means a person has been continuously insured under the Policy and prior Health Insurance policies issued to the Policyholder. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for Expenses payable under prior policies in the absence of the Policy. Previously insured dependents and students or scholars must re-enroll for coverage in order to avoid a break in coverage within 31 days of the end of the prior coverage to maintain coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs, the definition of Injury and Sickness will apply in determining coverage of any condition which existed during such break.

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 the 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 the Policy are sought and to notify the Company

of his or her decision within such 30 day period.

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 the 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.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of a Covered Person against any Third Party or coverage.

“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.

TRAVEL GUARD **Procedures on How to Access Travel Guard** **24-hour Assistance Call Center**

How to Contact Travel Guard:

- Inside the U.S. and Canada, dial 1-800-626-2427 toll-free.
- Outside the U.S. 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 Houston, TX, USA at 713-267-2525.
- Our fax number is 01-262-364-2203.

When to Contact Travel Guard:

- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is a question.

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 Doctors 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 doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

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

- Advise Travel Guard who you are insured by.
- Provide your Policy number, [CHH8036294/CAS9495383](https://www.chh.com/CHH8036294/CAS9495383)
- 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

Information/General: These services 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
- * Environmental & Political Warnings

Technical: These services provide 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 Sickness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

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

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 post-case payment/billing coordination on the traveler's behalf. These services include Doctor/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
- * Out-patient Assistance
- * In-patient Assistance

STUDENT ASSIST SERVICES

Concierge Services: You receive the comfort, care, and attention of Student Assist'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 Student Assist's Personal Security Assistance at home or while traveling. To activate personal security services, please log on to: <http://aig.com/travelguardassistance>.

For initial setup:

1. Click on 'Sign In' in the upper right-hand corner.
2. Click on 'Register Here'.
3. Enter the required information: first name, last name, email address, policy # 9495331, and then click 'Submit'.

REPATRIATION OF REMAINS/ EMERGENCY EVACUATION BENEFITS

REPATRIATION OF REMAINS BENEFIT

\$25,000 Maximum Amount per Covered Person

If a Covered Person suffers loss of life due to Injury or Emergency Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person. Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible. Travel Guard must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance.

EMERGENCY EVACUATION BENEFIT

\$25,000 Maximum Amount per Covered Person

The Company will pay, subject to the limitations set out herein, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. Travel Guard must make all arrangements and must authorize all expenses in advance for any Emergency 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.

Covered Persons are also entitled to the following travel and medical assistance services. These services are not affiliated with, nor endorsed by, National Union Fire Insurance Company of Pittsburgh, Pa.

For more details visit

<http://www.studentinsurance.com/Schools/MI/Wayne>

CLAIM FILING 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.

CLAIMS

AIG, Educational Markets Mail Center
P.O. Box 26050
Overland Park, KS 66225
Website: www.studentinsurance.com
1-888-622-6001

Questions regarding benefits, specific claim information and periods of coverage should be directed to the address or Customer Service phone number listed above.

Visit [http://www.studentinsurance.com/Schools/MI/Wayne/](http://www.studentinsurance.com/Schools/MI/Wayne) to access the following functions:

- Pharmacy Benefit Manager

Review pertinent account information:

- Verification of Insurance
- Download Online ID Card
- Check Claim Status
- Policy Brochure
- PPO Link

At AIG, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more privacy information, please go to the website at <http://www.studentinsurance.com/Schools/MI/Wayne/>.

NON-RENEWABLE ONE YEAR TERM 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.