



# Wayne State University

("the Policyholder")

## Student Health Insurance Plan For International Students

### 2014 - 2015



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

Administrator Policy #: CHH8036295  
Underwriter Reference #: CAS9495384

Keep this brochure as a general summary of the insurance

Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-MI. The Policy and Certificate on file at the University contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy and Certificate. A Certificate of Coverage is available to the Covered Student upon request. If there is any conflict between the contents of this brochure and the Policy, the Policy shall govern. Travel Assistance services provided by Travel Guard. Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at [www.AIG.com](http://www.AIG.com).

### 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 any amount of credit hours at Wayne State University are eligible for coverage under the WayneStateUniversityStudent Health Insurance Plan ("the Plan"). Eligible international students and scholars are required to enroll in the Plan by the appropriate enrollment deadline listed below. An international student and scholar will not be permitted to attend classes at the University until he or she is enrolled under the Student Health Insurance Plan. To enroll, eligible students and scholars can either log into their secure online account, or visit <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 located in the Welcome Center Building.

An eligible student or scholar may also enroll his or her eligible dependents online by logging into their secure online account or visit <http://www.studentinsurance.com/schools/MI/Wayne/> prior to the enrollment deadline noted below. 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.

Enrollment Period	Enrollment Deadline
Annual .....	10/16/14
Fall.....	10/16/14
Winter .....	01/25/15
Winter/Spring/Summer .....	01/25/15
Summer .....	07/03/15

The annual cost for a student or scholar and their eligible dependents to enroll in the Plan is:

Student under the age of 30:	\$ 1,255.00
Student 30 and older:	\$ 1,837.00
Spouse of Student under age 30:	\$ 2,968.00
Spouse of Student age 30 and older:	\$ 4,221.00
Each Child:	\$ 1,813.00

The Plan includes medical evacuation, repatriation and travel assistance services. An eligible student or scholar must actively attend classes at the University 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 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.

### EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on August 1, 2014 and terminates at 11:59 p.m. on July 31, 2015.

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 coverage for a Covered Student's or Scholar's dependent will end when the insurance coverage for the Covered Student or Scholar ends.

### **CERTIFICATE OF CREDITABLE COVERAGE**

The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Policy is terminated. In addition, Certificates shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time. In order to obtain a Certificate of Creditable Coverage, please contact AIG, Educational Markets, at 1-888-622-6001, or log into your account to print the Certificate of Creditable Coverage at [www.studentinsurance.com](http://www.studentinsurance.com)

### **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.

“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 the 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; (b) as a nursing or rest home; (c) as a place for custodial or educational care; or (d) 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.



“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.



## SCHEDULE OF BENEFITS

**Annual Maximum Benefit (all conditions combined)**

Unlimited

**Deductible:** \$150 per Policy Year per Covered Person\*

**\*Referral required (see Student Health Center Referral Section)**

**Out-of-Pocket Limit: \$5,000 per Covered Person / \$10,000 per Family**

This is a benefit that will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit shown above. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable due to covered percentages less than 100%. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary; expenses incurred for prescription drugs; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy. When this benefit becomes applicable to a Covered Person during a Policy Year, covered percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person in the remainder of that Policy Year up to any benefit maximum that may apply.

ELIGIBLE MEDICAL SERVICES	IN-NETWORK	NON-NETWORK
<b>INPATIENT BENEFITS</b>		
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 (Hospital confinement must occur within 3 days of testing)	80% of Allowable Charges	60% of R&C Charges
Physiotherapy	80% of Allowable Charges	60% of R&C Charges
Surgical Expense	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
Alcoholism and Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness
<b>OUTPATIENT BENEFITS</b>		
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 Expense	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/Occupational Therapy - 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 and Non-Scheduled Surgery (use of emergency room and supplies)	80% of Allowable Charges	80% of R&C Charges

ELIGIBLE MEDICAL SERVICES	IN-NETWORK	NON-NETWORK
<b>OUTPATIENT BENEFITS</b>		
Laboratory and X-Ray Examinations, CAT Scan/MRI/PET Scan	80% of Allowable Charges	60% of R&C Charges
Radiation Therapy and Chemotherapy	80% of Allowable Charges	60% of R&C Charges
Mental and Nervous Disorders	Same as any other Sickness	Same as any other Sickness
Urgent Care Expenses	80% of Allowable Charges	60% of R&C Charges
Hospice Care Expenses (limited to 45 days per year)	80% of Allowable Charges	60% of R&C Charges
Home Health Care Expenses (limited to 45 days per year)	80% of Allowable Charges	60% of R&C Charges
Skilled Nursing Facility Expense (limited to 45 days per year)	80% of Allowable Charges	60% of R&C Charges
Preventive Services Benefit includes preventive services such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act. To view a list of covered preventive services, log onto: <a href="http://www.hhs.gov/healthcare/prevention/index.html">www.hhs.gov/healthcare/prevention/index.html</a>	100% of Allowable Charges (not subject to deductible or co-payment amounts)	60% of R&C Charges
Consultant's Fees Expense	80% of Allowable Charges	60% of R&C Charges
Alcoholism and Substance Abuse Expense -Outpatient and Intermediate Care Facility	Same as any other Sickness	Same as any other Sickness
Prescribed Medicine Expense The Preferred Providers for prescriptions are through Informed Rx Of the Catamaran Corporation. For the complete listing of providers, Go to <a href="http://www.studentinsurance.com/Schools/MI/Wayne/">http://www.studentinsurance.com/Schools/MI/Wayne/</a> Benefits include prescribed FDA approved birth control methods	100% of Eligible Expenses subject to the following co-payment amount per 30 day supply Generic: \$25.00 Co-Pay Brand Name: \$50.00 Co-Pay The co-pay amount will be waived for prescribed FDA approved birth control methods	
Maternity Care	Same as any other Sickness	Same as any other Sickness
Injections and/or Immunizations	80% of Allowable Charges	60% of R&C Charges
<b>OTHER SERVICES</b>		
Ambulance Expense	80% of Allowable Charges	80% of Allowable Charges
Durable Medical Equipment/Braces and Appliances (only upon a Doctor's written prescription)	80% of Allowable Charges	60% of R&C Charges
Dental Treatment Expense (Injury only)	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:		
Preventive Services	80% of R&C Charges	80% of R&C Charges
Basic Services	50% of R&C Charges	50% of R&C Charges
Pediatric Dental Treatment Expense: (Covered Persons under age 19 only) limited to 2 oral exams per Policy Year Preventive Services	100% of Allowable Charges	
Pediatric Vision Care Expense: (Covered Persons under age 19 only) limited to 1 set of lenses and frames per Policy Year		
Examinations	\$ 25 Co-pay per visit	
Materials	\$75 Co-pay per visit	
Maximum amount Per Policy Year	Unlimited	
Standard Plastic Lenses: Single Vision, Bifocal, Trifocal, Lenticular, Progressive	\$50 Co-pay per visit	

### EXCLUSIONS AND LIMITATIONS

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

1. as a result of dental treatment, or dental x-rays except as provided elsewhere in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy; hearing aids or prescriptions or examinations for such except as required for repair caused by a covered Injury. Vision examinations not related to prescription or fitting of lenses will be covered only when performed in connection with the diagnosis or treatment of Sickness or Injury. Eye refraction is not covered. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a 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 Benefits 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 except as specifically provided in the policy.

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 loss due to voluntary use of any drug, narcotic or controlled substance, unless prescribed by a Doctor.
18. for surgery and/or treatment of: acne; biofeedback-type services; corns, calluses and bunions; deviated nasal septum, including submucuous resection and/or other surgical correction thereof unless due to Injury occurring while coverage is in force; fertility tests; hair growth or removal; impotence, organic or otherwise; nonmalignant warts, moles and lesions; premarital examinations; sexual reassignment surgery and related therapy; sleep disorders, including supplies, treatment and testing thereof. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
19. 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 Benefits mandated by the Patient Protection and Affordable Care Act.
20. 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.
21. for organ, tissue and cell transplants.
22. for voluntary or elective abortions.
23. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from professional and semi-professional sports; scuba diving; hang gliding; parachuting; or any other hazardous sport or hobby.
24. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
25. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
26. within the Covered Person's home country of domicile with respect to an international Covered Person.
27. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

**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, results 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 required 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) an Emergency Medical Condition.

Benefits for Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or Non-PPO provider.

The deductible amount 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.

Persons insured under the Plan may choose to be treated within or outside of the Cofinity PPO Network. Reimbursement rates will vary depending upon the source of care as described under the

### **PREFERRED PROVIDER ORGANIZATION**

Cofinity Toll-Free Telephone Number: 800-226-5116

Cofinity Website: [www.cofinity.net](http://www.cofinity.net)

If a Covered Person seeks treatment from a Non- PPO 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 percentage (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.

### **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 the 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, the Policyholder or the Covered Person.

This provision will not apply if it is prohibited by law.



## **TRAVEL GUARD**

### **Description of Travel Assist and Student Assist Services**

#### **Procedures on How to Access Travel Guard and Student Assist Services 24 Hour Assistance Call Services**

##### **How to Contact Travel Guard:**

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

##### **When to Contact Travel Guard:**

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

Travel Guard is available 24-hours-a-day/7-days-a-week/365-days-a-year.

Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home.

The Travel Guard Medical Staff consists of full-time, onsite Registered Nurses and emergency 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 of your insurance company name
- Provide your Policy number, (CHH8036295/CAS9495384) or School Name.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

## Travel Guard Description of Services

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

- \* Visa & Immunization
- \* Weather & Exchange Rates
- \* Environmental & Political Warnings

### Technical:

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

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

**Medical:** These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network providers and often include 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

Medical Transport:

- Emergency Evacuation
- Repatriation of Remains

## STUDENT ASSIST SERVICES

**Concierge Services:** You receive the comfort, care, and attention of Travel Guard's Personal Assistance Coordinators available 24/7 to respond to virtually any request – large or small.

**Personal Security Assistance:** You can feel safe and secure with Travel Guard's Personal Security Assistance at home or while traveling.

To activate personal security services, please visit [www.studentinsurance.com](http://www.studentinsurance.com) and log into your secure online account. For more details visit [www.studentinsurance.com](http://www.studentinsurance.com).

### REPATRIATION OF REMAINS/ EMERGENCY EVACUATION BENEFITS (Provided by National Union Fire Insurance Company of Pittsburgh, Pa.)

#### REPATRIATION OF REMAINS BENEFIT \$25,000 Maximum Amount

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

The Company will pay, subject to the Policy limitations, 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.

### 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](http://www.studentinsurance.com), log into your account and click on 'student options'. The claim form can be submitted online electronically. A claim form can also be submitted via regular mail to AIG, Educational Markets Mail Center, P.O. 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.

### CLAIMS CUSTOMER SERVICE

AIG, Educational Markets Mail Center  
P.O. Box 26050  
Overland Park, KS 66225  
Website: [www.studentinsurance.com](http://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/> to access the following functions:

- Participating Pharmacies
- Review pertinent account information
- Online Enrollment for Dependents
    - Verification of Insurance
  - Download Online ID Card
  - Check Claim Status
  - 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.

This brochure is a brief description of the Student Health Insurance Plan available under policy series S30749NUFIC-PPO-MI. The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file with Wayne State University. If there is any conflict between the contents of this brochure and the Policy, the Policy will govern in all cases. Travel Assistance services provided by Travel Guard. Insurance and services provided by member companies of American International Group, Inc. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at [www.AIG.com](http://www.AIG.com).