2015 - 2016
Student Health
Insurance Plan
(“the Plan”)

Designed for the Students of

Tuskegee University
(“the Policyholder”)
Tuskegee, AL
www.summitamerica-ins.com/tuskegee

Administrator Policy Number: CHH8050556
Underwriter Reference Number: CAS9149530

INSURANCE UNDERWRITTEN BY:
National Union Fire Insurance Company of Pittsburgh, Pa.,
with its principal place of business in New York, NY ("the Company")

Please keep this brochure as a general summary of the insurance. This is only a brief description of
the coverage available under policy series S30749NUFIC-PPO-AL. The Policy on file at the University
contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the
coverage are contained in the Policy. If there is any conflict between the contents of this document
and the Policy, the Policy shall govern.

Travel Assistance services provided by Travel Guard Group, Inc. ("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.
**Welcome to Tuskegee University Student Health Services!**

The Tuskegee University Student Health Services as a unit in the Division of Student Affairs provides Health Care and Education to all enrolled students, in accordance with the institutional mission and philosophy. The Student Health Services is committed to provide students with quality primary health care services, and encourage the use of preventive methods through health education and counseling.

**Eligibility for Student Health Services**

All currently enrolled students, except for employees of Tuskegee who are matriculating, are eligible to receive health services, information and counseling at the Student Health Services. The student is required to present a valid student ID to receive services. Dependents are not eligible for services at the Student Health Center.

**Hours of Operation**

Fall, Spring and Summer Semesters: Monday-Friday 8am-4:30pm

The students are seen on a walk-in basis, on the same day, with the last sign-in at 3:30pm.

**Location**

Suite 71-235, John A. Kenney Hall

Telephone: 334-727-8641

Fax: 334-724-4437

E-mail (Director): samue@mytu.tuskegee.edu

**Medical Emergencies**

For ALL on-campus medical emergencies, students must call *911* for assistance. For ALL serious medical emergencies off-campus, students should call *911*.

Students will be transported to the emergency room by ambulance, in case of all serious emergencies. For minor emergencies, students will be transported to the Student Health Services, during office hours, or advised to go the next business day.

*If away from campus, students should call 911 or go directly to the nearest emergency room.*

**The Student Health Services Staff**

The Student Health Services Staff includes: The Director, Full-time Doctor, Registered Nurses, Licensed Practical Nurse, and Medical Assistants.

*ALL patient visits to the Medical Providers at the Student Health Services are free of charge.*

**Services Provided**

Medical conditions commonly encountered and treated at any Primary Health Care Center: diseases in young adults such as illness of the respiratory, digestive, dermatologic, genitourinary systems, and STDs.

Minor injuries, insect bites, animal bites, traumas from sprains to fractures are also frequently encountered.

Monitoring of chronic illnesses, such as Hypertension, Diabetes, Asthma and Allergy injections are administered.

Mental health: Frequent problems encountered include, anxiety, mild to moderate depression, stress-related disorders and eating disorders. As appropriate, referrals are made to mental health professionals.

Arrangements for Rabies Immunizations are made through the School of Veterinary Medicine, and administered at the Student Health Services. There is no cost to students in Veterinary Medicine for the required rabies vaccinations.

**Medications and Medical Supplies**

All medications and medical supplies dispensed at the Student Health Center are free of charge. Prescriptions are written for the medications that are not available at the Student Health Services.

**Laboratory Services**

A few in-house lab tests are available free of charge, such as urinalysis, pregnancy tests, and rapid strep and rapid influenza tests. All other lab services are done through samples sent to Lab Corp., and reimbursed as per Student Health Insurance Plan, subject to all terms of the Policy.

*For X-rays, Ultrasounds, and other Scans, students are referred to local imaging centers and Hospitals.*

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**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Tuskegee University Student Health Services</td>
<td>3</td>
</tr>
<tr>
<td>Eligibility for Services</td>
<td>3</td>
</tr>
<tr>
<td>Hours of Operation</td>
<td>3</td>
</tr>
<tr>
<td>Location</td>
<td>3</td>
</tr>
<tr>
<td>Medical Emergencies</td>
<td>3</td>
</tr>
<tr>
<td>The Student Health Services Staff</td>
<td>3</td>
</tr>
<tr>
<td>Services Provided</td>
<td>3</td>
</tr>
<tr>
<td>Medications and Medical Supplies</td>
<td>3</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>3</td>
</tr>
<tr>
<td>Referral Services</td>
<td>4</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation</td>
<td>4</td>
</tr>
<tr>
<td>Wellness and Health Promotion Programs</td>
<td>4</td>
</tr>
<tr>
<td>Community Service Outreach Programs</td>
<td>4</td>
</tr>
<tr>
<td>Health Clearance Requirements for New Students</td>
<td>4</td>
</tr>
<tr>
<td>Contact Information</td>
<td>5</td>
</tr>
<tr>
<td>Tuskegee University Student Health Insurance Plan</td>
<td>6</td>
</tr>
<tr>
<td>Eligibility</td>
<td>6</td>
</tr>
<tr>
<td>Plan A Rates</td>
<td>6</td>
</tr>
<tr>
<td>Plan B Rates</td>
<td>7</td>
</tr>
<tr>
<td>Dependents</td>
<td>7</td>
</tr>
<tr>
<td>Effective and Termination Dates</td>
<td>7</td>
</tr>
<tr>
<td>Termination of Policy</td>
<td>7</td>
</tr>
<tr>
<td>Preferred Provider Information</td>
<td>7-8</td>
</tr>
<tr>
<td>Script Care Pharmacy Network</td>
<td>8</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Benefit</td>
<td>8</td>
</tr>
<tr>
<td>Certificate of Creditable Coverage</td>
<td>9</td>
</tr>
<tr>
<td>Mandated Benefits</td>
<td>9</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>9</td>
</tr>
<tr>
<td>Continuation of Coverage</td>
<td>9</td>
</tr>
<tr>
<td>Plan A Referral Requirement</td>
<td>10</td>
</tr>
<tr>
<td>Plan A Schedule of Medical Benefits</td>
<td>11-13</td>
</tr>
<tr>
<td>Plan B Schedule of Medical Benefits</td>
<td>14-16</td>
</tr>
<tr>
<td>Vision and Dental Discount Schedule of Benefits</td>
<td>13 &amp; 16</td>
</tr>
<tr>
<td>Repatriation of Remains/Medical Evacuation</td>
<td>17</td>
</tr>
<tr>
<td>Definitions</td>
<td>17-22</td>
</tr>
<tr>
<td>Exclusions and Limitations</td>
<td>22-24</td>
</tr>
<tr>
<td>Subrogation</td>
<td>24</td>
</tr>
<tr>
<td>Travel Assist and Student Assist Services</td>
<td>24-25</td>
</tr>
<tr>
<td>Privacy Policy</td>
<td>25</td>
</tr>
<tr>
<td>Careington Dental</td>
<td>26</td>
</tr>
<tr>
<td>Discount Vision Program</td>
<td>26</td>
</tr>
<tr>
<td>New Directions Behavioral Health Student Assistance Plan</td>
<td>26</td>
</tr>
<tr>
<td>Online Services</td>
<td>26</td>
</tr>
<tr>
<td>Claims Procedures</td>
<td>27</td>
</tr>
<tr>
<td>Contact Information &amp; ID Card</td>
<td>28</td>
</tr>
</tbody>
</table>
Referral Services

Referral services are provided, if indicated, to most of the area Hospitals, Medical Specialists, Clinics and other health facilities through a referral network. The student must be seen by the medical providers at the Student Health Center for all referrals. See page 8 for exceptions to the referral requirement. The Referral Requirement is applicable to students enrolled in Plan A only. A referral from Student Health Services is required before benefits are payable.

Non-Emergency Medical Transportation

Tuskegee University provides free non-medical transportation to assist students, who are referred to the Hospital, specialists, clinics and medical facilities. The Student Health Services staff can assist in making arrangements, and the University will provide return transportation service for students who have been transported.

*To make transportation arrangements for scheduled medical appointments, students must come in person with their student ID at least 2-3 days (48-72 hours) in advance to signing the transportation request form. All cancellations also require 2-3 days (48-72 hours) notice.

Wellness and Health Promotion Programs

Wellness and Health Promotion Programs are an important part of the Student Health Services. Throughout the year a number of educational programs are presented in an effort to improve student awareness regarding common health problems and behavior students should practice in order to reduce their health risks with emphasis placed on Healthy Lifestyles, Drug and Alcohol awareness, Prevention of STDs and HIV etc. The Health Education Programs are comprehensive and provide education, support and resources to advance the health and wellness of students and the entire Campus community.

Community Service Outreach Programs

The Community Service Outreach Programs are organized and implemented, in accordance with the institutional mission to provide services to the campus community, regional and national levels.

Health Clearance Requirements for New Students

As per the Alabama Department Public Health guidelines, and University policy, ALL Students enrolling at Tuskegee University for the first time are required to complete and submit:

- A Complete Health Profile form
- Proof of immunizations – two doses of the Measles or MMR Vaccine
- A TB skin test with results (done within six months before enrollment)

The Health Clearance will be then issued, to complete the registration process.

CONTACT INFORMATION

Mailing Address
Student Health Services
Suite 71-235, John A. Kenney Hall
Tuskegee University
Alabama 36088

Telephone Numbers
Main Desk: 334-727-8641
Physician and Nurses: 334-727-8642
Fax No: 334-724-4437

Director, Student Health and Counseling Services
Telephone Number: 334-727-8647
E-mail: samuelj@mytu.tuskegee.edu

TUSKEGEE UNIVERSITY CAMPUS EMERGENCY NUMBERS

Tuskegee University Police Department ..................................................... 727-8757
Emergency Medical Services ................................................................. 727-8244
Counseling Center .................................................................................. 727-4746
Office of the Dean of Chapel ................................................................. 727-8322 or 8702
Dean of Students ................................................................................... 727-8421
Residence Life and Development ........................................................ 727-8915 or 8930
Housing ................................................................................................. 727-8100 or 4617

CITY OF TUSKEGEE EMERGENCY NUMBERS

City of Tuskegee Police ........................................................................ 727-0200
Macon County Sheriff .......................................................................... 727-2500
City of Tuskegee Fire Department ......................................................... 727-2900

LOCAL CLINICS

Tuskegee Quality Care
707 W. Martin Luther King Highway
Tuskegee, AL 36088
Contact: Ms. Ella Robinson
Phone: 334-727-7211

Auburn Urgent Care
1650 S. College Street
Auburn, AL 36832
Contact: Ms. Shirl Hicks
Phone: 334-821-3221
Tuskegee University Student Health Plan (“the Plan”)

The following is a brief description of the Plan offered to the students of Tuskegee University and their eligible Dependents.

Eligibility

Plan A

All registered students at Tuskegee University are automatically enrolled in Plan A and the applicable premium is charged to their tuition bill each semester.

An eligible student must actively attend classes at the University for at least the first 30 days of the period for which he or she is enrolled. Except in the case of withdrawal from school due to Sickness or Injury, any student withdrawing from school during the first 30 days of the period for which he or she is enrolled will not be covered under the Policy and a full refund of premium will be made less any claims paid. Students who withdraw after such 30 days will remain covered under the Policy and no refund will be made.

Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that 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.

Plan A - Premium Rates*

<table>
<thead>
<tr>
<th>Coverage Term</th>
<th>Student: Plan A Rate included in Student Tuition</th>
<th>Spouse: Plan B</th>
<th>Children: Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Coverage Term 08/12/2015-01/06/2016</td>
<td>$475</td>
<td>$665</td>
<td>$238</td>
</tr>
<tr>
<td>Spring/Summer Coverage Term 01/07/2016-08/11/2016</td>
<td>$665</td>
<td>$665</td>
<td>$665</td>
</tr>
<tr>
<td>Summer Coverage Term 06/02/2016-08/11/2016</td>
<td>New Students to the University in the Summer Coverage Term only</td>
<td>$238</td>
<td>$238</td>
</tr>
</tbody>
</table>

*Premium includes administrative fees.

Plan B (enhanced Plan)

Students charged for Plan A may choose to upgrade to the enhanced Plan B by completing the enrollment process and submitting the appropriate premium by the enrollment deadline. To enroll in Plan B, go to www.summitamerica-ins.com/tuskegee. Enrollment must be completed by 11/12/15 for the Fall term, by 03/07/16 for the Spring/Summer term and by 08/01/16 for the Summer term.

Plan B (enhanced) eliminates the following from Plan A:
- Student Health Services referral requirement;
- Co-pay amounts, other than Prescribed Medicines.

Effective and Termination Dates

The Policy, on file with Tuskegee University, becomes effective at 12:01 a.m. on August 12, 2015. The coverage of an eligible student shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the day after the date for which the first premium for the Covered Student’s coverage is received by the Company; (3) the date the Policyholder’s term of coverage begins; or (4) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder. An eligible student may enroll for coverage for his or her Dependent only under the following conditions: within 31 days of marriage, birth or adoption or placement for adoption, or arrival in the U.S.

The Policy terminates at 11:59 p.m. on August 11, 2016. Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur: (a) the date the Policy terminates; (b) the last day for which any required premium has been paid or; (c) the date on which the Covered Student withdraws from the school because of withdrawal from the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made within 90 days of leaving school); or (2) when withdrawal from school during the first 30 days of the period for which the student is enrolled and is for a reason other than withdrawal from school due to Sickness or Injury. A full refund of premium will be made (less any claims paid) when written request is made within 90 days of leaving school. If withdrawal from the Policyholder’s school is for other than (1) or (2) above, no premium refund will be made. Students, including those who withdraw from the Policyholder’s school during the first 30 days due to Injury or Sickness, 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 Dependent will end when insurance for the Covered Student ends.

Policy Information

The Policy is issued for the Policy Term shown in the Schedule of Benefits in the Policy on file at the University. If the Policyholder desires to continue coverage, the Company will issue a new Policy for a new Policy Term, subject to the then current underwriting requirements.

Preferred Provider Information

The Plan provides access to Hospitals and health care providers locally and across the country through the First Health Preferred Provider Organization (“PPO”). While the Covered Person may utilize any provider he or she chooses, he or she will decrease his or her out-of-pocket expenses if he or she receives care locally and nationally through the First Health Provider Network. Use of this network of providers is optional.

A PPO is an organization in which a group of Doctors, Hospitals, and other health care providers who are contracted to provide medical care at a negotiated fee, or Allowable Charge. It is to the advantage of the Covered Person to use the PPO to help reduce out-of-pocket expenses, as any applicable coinsurance is based on the Allowable Charge. Non-PPO Providers have not agreed to an Allowable Charge and consequently the Covered Person’s out-of-pocket costs may be greater.
The Covered Person should be aware that PPO Hospitals may be staffed with Non-PPO Providers. Receiving services or care from a Non-PPO Provider at a PPO Hospital does not guarantee that all charges will be paid at the PPO Provider level of benefits. It is important that the Covered Person verify that his or her Doctors are Network Providers when calling for an appointment or at the time of service.

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.

The most efficient and accurate way to identify participating First Health Providers is by visiting their website at www.myfirsthealth.com, or call 1-800-226-5116.

**Script Care Pharmacy Network**
Each prescription or refill that is obtained at a Script Care participating pharmacy for a covered Sickness or Injury is subject to:
- $10 Co-pay for generic drugs
- $25 Co-pay for formulary brand name drugs
- $40 Co-pay for nonformulary brand name drugs
- 20% of charges with a $100 minimum - $200 maximum Co-pay for Specialty brand name drugs
- $0 Co-pay for FDA-approved contraceptives

Each prescription or refill is limited to a 30-day supply. Covered Persons should present their ID card to the Script Care participating pharmacy when the prescription is filled. If the Covered Person does not present his or her ID card when the prescription is filled, he or she will have to pay for the prescription and then submit a reimbursement form along with the paid receipt in order to be reimbursed. To obtain reimbursement forms or for information about mail-order prescriptions or network pharmacies, please call the Script Care Pharmacy Help Desk toll free at 1-877-439-7344 or visit their website at www.scriptcare.com.

**Accidental Death and Dismemberment Benefits**
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. The amount of this benefit is shown in the table below.

<table>
<thead>
<tr>
<th>Loss Description</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>Two hands</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>Two feet</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>Sight of two eyes</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>One hand and sight of one eye</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>One foot and sight of one eye</td>
<td>Maximum amount $10,000</td>
</tr>
<tr>
<td>One hand or one foot and sight of one eye</td>
<td>Maximum amount $10,000</td>
</tr>
</tbody>
</table>

*Loss* of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means the total, irrevocable loss of the entire sight in that eye. “Severance” means the complete separation and dismemberment of the part from the body.

### Certificate of Creditable Coverage
Coverage under the Plan is “creditable coverage” under Federal law. 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. When coverage terminates, the Covered Person can request a Certificate of Creditable Coverage which is evidence of his or her coverage under the Plan. In order to obtain a Certificate of Creditable Coverage please contact Summit America Insurance Services at 1-800-890-8755.

**Mandated Benefits**
The Plan covers applicable Mandated Benefits as required by the State of Alabama. Please see the Policy on file with the University for details.

**Extension of Benefits**
If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital confinement. Such benefits will be payable until the earliest of: (1) the date the Hospital confinement ends; (2) the end of the 90 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached. The Extension of Benefits will only apply 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.

**Continuation of Coverage**
A Covered Person whose coverage under the Plan terminates for any reason except involuntary termination may continue coverage for an additional 6 months beyond the date his or her coverage terminates if the Plan or a successor Policy issued by the Company is in force. Written request for continuation for the Covered Student and his or her previously insured Dependents and payment of premium must be received by the Company within 31 days following the later of: (a) the date the coverage under the Plan terminates; or (b) the date notice of the right of continuation is given by this Policyholder. Coverage may be continued for the remainder of the Policy Year at a premium that is not more than the premium charged for coverage under the Plan. Continuation of coverage will be subject to all of the terms of the Plan.
PLAN A: SCHEDULE OF BENEFITS

Student Health Services Referral Required.

Students MUST FIRST use the services of the University Student Health services where treatment will be administered and/or referral issued for outside treatment.

Plan A - Referral requirement:
In many cases, student’s health care needs may best be satisfied when an organized system of health care providers at Tuskegee University Health Services manages the treatment. A referral from Student Health Services is required before benefits are payable.

This referral requirement does not apply if: (a) Student Health Services is closed; (b) covered service is rendered at another facility during school breaks or vacation times; (c) medical care is received when student is more than 30 miles from campus; (d) medical care is obtained by a student who is not eligible to use Student Health Services; (e) for maternity; (f) for mental disorders; (g) for annual routine gynecological/obstetrical services; (h) Emergency Medical Condition; or (i) preventive health services. Benefits for Eligible Expenses incurred for medical care or treatment rendered for which a referral is required but not obtained will be excluded from coverage. No authorization or referral requirement shall apply to obstetrical or gynecological care provided by in-network providers. Benefits for Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or Non-PPO provider. This referral requirement does not apply to the Covered Student’s Dependents.

Aggregate Maximum Benefit per Policy Year: Unlimited

Deductible Amount per Policy Year per Covered Person:
In-Network: $250
Out-of-Network: $750

Out-of-Pocket Limit per Policy Year:
Per Covered Person:
In-Network: $6,600
Out-of-Network: $13,200
Per Family:
In-Network: $13,200
Out-of-Network: $26,400

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 & Customary (“R&C”); charges in excess of any specified maximum or charges incurred for any services not covered under the Policy.

When this benefit becomes applicable to a Covered Person during a Policy Year, Covered Percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person in the remainder of that Policy Year up to any benefit maximum that may apply.

If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out-of-Pocket, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible medical Expense incurred by such Covered Student and his covered Dependents for the rest of that Policy Year. When the Family Out-of-Pocket Limit is reached, the Covered Percentage will be increased to 100% of the Eligible Expenses incurred for the remainder of that year.

Plan A Eligible Expenses Include:

### INPATIENT

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board Expense, except if intensive Care Unit, limited to the average semi-private room rate</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses, includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays (including professional fees); oxygen tent; drugs, medicines, dressings; and other Medically Necessary and prescribed Hospital expenses</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Pre-admission Testing, Hospital confinement must occur within 3 days of the testing</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (PNP) provided such care is: (a) rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Radiology Therapy, and Chemotherapy during Hospital Confinement</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Surgical Expense, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon’s Fees</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia, professional services administered in connection with inpatient surgery</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>In-Hospital Doctor’s Fees Expense, (other than a Doctor who performed surgery or administered anesthesic), limited to one visit per day and not related to Physiotherapy</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Alcoholism/Substance Abuse Expenses</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Psychiatric Conditions Expense, (Mental and Nervous Disorders)</td>
<td>100% of Allowable Charge</td>
<td>100% of R&amp;C</td>
</tr>
</tbody>
</table>
### OUTPATIENT

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed.</td>
<td>100% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon’s Fees</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia, professional services administered in connection with outpatient surgery</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Day surgery facility/Miscellaneous: When scheduled surgery is performed in a Hospital or outpatient facility, including the 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), R&amp;C Charges for Day Surgery Misc, are based on the most recent edition of the Outpatient Surgical Facility Charge Index.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Non-Surgical Only (outpatient services performed in a Hospital including, but not limited to: diagnostic x-ray and laboratory services; radiation therapy and chemotherapy; diagnostic services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and laboratory procedures)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient expenses: laboratory and x-ray examinations (not otherwise covered under Preventive Services); CAT Scan/MRI and/or PET Scan; radiation therapy and chemotherapy; diagnostic services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and laboratory procedures)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery, the Co-pay Amount will be waived if the Covered Person is admitted to the Hospital as an inpatient. After a $200 Co-pay Amount per visit, 100% of Allowable Charge.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Urgent Care expense, includes benefit for Urgent Care Provider to evaluate and treat an Urgent Condition.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Out of Hospital Doctor’s Fees Expense (Doctor (other than Specialist) or Specialist), limited to one visit per day per Doctor. Benefits do not apply when related to surgery or Orthoptherapy.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Preventive services, includes preventive services such as screenings, exams, and immunizations specified by the Patient Protection and Affordable Care Act. To view a list of covered preventive services go to <a href="http://www.hhs.gov/healthcare/prevention/index.html">http://www.hhs.gov/healthcare/prevention/index.html</a>.</td>
<td>100% of Allowable Charge. Not subject to Deductible or Co-Pay Amounts</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitation Services/Nutritive Services (Physical Therapy, Occupational Therapy, Cardiac/Pulmonary, Chiropractic, Speech Therapy)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Injections and/or Immunizations (not otherwise covered under Preventive Services)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Prescribed Medicines Expense, limited to 30-day supply per prescription. This benefit applies to all prescribed FDA-approved birth control methods. The Co-pay will be waived for prescribed FDA-approved birth control. See page 7 for more information.</td>
<td>100% of R&amp;C subject to the following Co-pay Amount per prescription/refill:</td>
<td></td>
</tr>
<tr>
<td>Alcoholism/Substance Abuse Expenses</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Psychiatric Conditions Expense (Mental and Nervous Disorders)</td>
<td>100% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic testing for Attention Deficit Disorders and learning Disabilities</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

### OUTPATIENT Continued

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant’s fees expense</td>
<td>After a $20 Co-pay Amount per visit, 100% of Allowable Charge</td>
<td>After a $20 Co-pay Amount per visit, 60% of R&amp;C</td>
</tr>
<tr>
<td>Infertility Services benefits are payable to diagnose cause of infertility, services for or related to artificial insemination, care needed to correct an underlying cause of infertility.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Sexual Dysfunction Services benefits are payable for services related to diagnosis, treatment and correction of any underlying causes of sexual dysfunction.</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Ambulance (the use of a professional ambulance in an emergency)</td>
<td>100% of Allowable Charge</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (replacement not covered) and Orthopedic Appliances/Braces and Appliances (payable only upon Doctor’s written prescription)</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dental Treatment expense (Injury Only)</td>
<td>100% of Actual Charge</td>
<td>100% of Actual Charge</td>
</tr>
<tr>
<td>Dental Treatment expense (Removal of impacted wisdom teeth)</td>
<td>100% of Actual Charge</td>
<td>100% of Actual Charge</td>
</tr>
<tr>
<td>Maternity/Complications of Pregnancy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Hospice Care Expense</td>
<td>80% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Pediatric Vision Care Expense (Covered Person under age 19 only)</td>
<td>100% of Actual Charge after the following Co-pay Amount per Policy Year:</td>
<td></td>
</tr>
<tr>
<td>Standard Plastic Lenses:</td>
<td>Maximum Amount per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$75</td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td>$140</td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Care Expense (for covered person age 19 and older) Limited to one routine eye examination, one pair of lenses and one frame per Policy Year</td>
<td>100% of Actual Charge after the following Co-pay Amount per visit:</td>
<td></td>
</tr>
<tr>
<td>Standard Plastic Lenses:</td>
<td>Maximum Amount per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$25</td>
<td></td>
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<tr>
<td>Bifocal</td>
<td>$25</td>
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<tr>
<td>Trifocal</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Progressive</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental Treatment expense (Covered Persons under age 19 only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-payment Amount Per Visit</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Covered Percentage</td>
<td>For Diagnostic and Preventive Services</td>
<td>50%</td>
</tr>
<tr>
<td>For Basic Services</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>For Primary Services</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>For Orthodontia</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>For Oral Examination (Preventive)</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable due to Covered Percentages less than 100%. The Out-of-Pocket Limit does not include charges in excess of R&C charges in excess of any specified maximum or charges incurred for any services not covered under the Policy.

When this benefit becomes applicable to a Covered Person during a Policy Year, Covered Percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person in the remainder of that Policy Year up to any benefit maximum that may apply.

If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out-of-Pocket, the Out-of-Pocket Limit will be deemed to be met with respect to enrollment in Student and his covered Dependents for the rest of that Policy Year. When the Family Out-of-Pocket Limit is reached, the Covered Percentage will be increased to 100% of the Eligible Expenses incurred for the remainder of that year.

Eligible Expenses Include:

### INPATIENT

<table>
<thead>
<tr>
<th>Description</th>
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<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board Expense, except if Intensive Care Unit, limited to the average semi-private room rate</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses: includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays (including professional fees); oxygen tent; drugs, medicines, dressings; and other Medically Necessary and prescribed Hospital expenses</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Pre-admission Testing: Hospital confinement must occur within 3 days of the testing</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: (a) rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Physiotherapy, Hydrotherapy, Occupational Therapy, Cardiac/Pulmonary Therapy during Hospital Confinement</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Radiation Therapy, and Chemotherapy during Hospital Confinement</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Surgical Expense, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed.</td>
<td>85% of Allowable Charge</td>
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<tr>
<td>Assistant Surgeon’s Fees</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia, professional services administered in connection with inpatient surgery</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>In-Hospital Doctor’s Fees Expense, (other than a Doctor who performed surgery or administered anesthesia), limited to one visit per day and not related to Physiotherapy</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Alcoholism/Substance Abuse Expenses</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Psychiatric Conditions Expense, (Mental and Nervous Disorders)</td>
<td>100% of Allowable Charge</td>
<td>100% of R&amp;C</td>
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</table>

### OUTPATIENT

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<tr>
<td>Surgical Expense, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed.</td>
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<td>Anesthesia, professional services administered in connection with outpatient surgery</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
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<tr>
<td>Day surgery facility/Miscellaneous: When scheduled surgery is performed in a Hospital or outpatient facility, including the use of the operating room, laboratory tests and x-ray examinations (including professional fees), anesthetic, infusion therapy, drugs or medicines and supplies, therapeutic services (excluding Physiotherapy or take home drugs and medicines), R&amp;C Charges for Day Surgery Misc. are based on the most recent edition of the Outpatient Surgical Facility Charge Index.</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Non-Surgical Only (outpatient services performed in a Hospital including, but not limited to: diagnostic x-ray and laboratory services, radiation therapy and chemotherapy; Physiotherapy; diagnostic services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and laboratory procedures).</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient expenses: laboratory and x-ray examinations (not otherwise covered under Preventive Services); CAT Scan/MRI and/or PET Scan; radiation therapy and chemotherapy; diagnostic services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and lab procedures) (not otherwise covered under Preventive Services).</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery, the Co-pay Amount will be waived if the Covered Person is admitted to the Hospital as an Inpatient.</td>
<td>100% of Allowable Charge</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Urgent Care expense, includes benefit for Urgent Care Provider to evaluate and treat an Urgent Condition.</td>
<td>100% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Out of Hospital Doctor’s Fees Expense (Doctor (other than Specialist) or Specialist, limited to one visit per day per Doctor. Benefits do not apply when related to surgery or Physiotherapy.</td>
<td>100% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Preventive services, includes preventive services such as screenings, exams, and immunizations specified by the Patient Protection and Affordable Care Act. To view a list of covered preventive services go to <a href="http://www.hhs.gov/healthcare/prevention/index.html">http://www.hhs.gov/healthcare/prevention/index.html</a>.</td>
<td>100% of Allowable Charge; Not subject to Deductible or Co-Pay Amounts</td>
<td>60% of R&amp;C</td>
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<tr>
<td>Preventive services, includes preventive services such as screenings, exams, and immunizations specified by the Patient Protection and Affordable Care Act. To view a list of covered preventive services go to <a href="http://www.hhs.gov/healthcare/prevention/index.html">http://www.hhs.gov/healthcare/prevention/index.html</a>.</td>
<td>100% of Allowable Charge; Not subject to Deductible or Co-Pay Amounts</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitation Services/Habilitation Services (Physical Therapy, Occupational Therapy, Cardiac/Pulmonary, Chiropractic, Speech Therapy).</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Injections and/or Immunizations (not otherwise covered under Preventive Services)</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Prescribed Medicine expense, limited to 30-day supply per prescription. This benefit applies to all prescribed FDA-approved birth control methods. The Co-pay will be waived for prescribed FDA-approved birth control. See page 7 for more information.</td>
<td>100% of R&amp;C subject to the following Co-pay Amounts per prescription/visit: Generic: $10 Formulary Brand Name: $25 Non-Formulary Brand Drug: $40 Specialty Brand Drug: 20% of charges with a $100 minimum - $200 maximum</td>
<td></td>
</tr>
<tr>
<td>Alcoholism/Substance Abuse Expenses</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Psychiatric Conditions Expense (Mental and Nervous Disorders)</td>
<td>100% of Allowable Charge</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic testing for Attention Deficit Disorders and learning Disabilities</td>
<td>85% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Consultant’s fees expense</td>
<td>100% of Allowable Charge</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>
### Infertility Services
- Benefits are payable to diagnose causes of infertility; for services related to artificial insemination, care needed to correct an underlying cause of infertility.
- Covered Percentage: 85% of Allowable Charge
- Don't exceed the Maximum Amount per Covered Person.
- In-Network: 50% of Allowable Charge
- Out-of-Network: 50% of Allowable Charge

### Sexual Dysfunction Services
- Benefits are payable for services related to diagnosis, treatment, and correction of any underlying causes of sexual dysfunction.
- Covered Percentage: 85% of Allowable Charge
- Don't exceed the Maximum Amount per Covered Person.
- In-Network: 50% of Allowable Charge
- Out-of-Network: 50% of Allowable Charge

### Other Services
- Ambulance (use of a professional ambulance in an emergency):
  - Covered Percentage: 100% of Allowable Charge
- Durable Medical Equipment (replacement not covered) and Orthopedic Appliances/Braes and Appliances (payable only upon Doctor's written prescription):
  - Covered Percentage: 85% of Allowable Charge
- Dental Treatment expense (Injury Only):
  - Maximum Amount per Policy Year: $100
- Maternity/Complications of Pregnancy:
  - Covered Percentage: 100% of Actual Charge
- Home Health Care Expense:
  - Covered Percentage: 85% of Allowable Charge
- Hospice Care Expense:
  - Covered Percentage: 85% of Allowable Charge

### Vision Care Expense
- Standard Plastic Lenses:
  - Single Vision:
    - Maximum Amount per Policy Year: $75
    - Materials: $25
  - Bifocal:
    - Maximum Amount per Policy Year: $100
    - Materials: $25
  - Trifocal:
    - Maximum Amount per Policy Year: $140
    - Materials: $25
  - Lenticular:
    - Maximum Amount per Policy Year: $140
    - Materials: $25

### Pediatric Vision Care Expense (Covered Persons under age 19 only)
- Covered Percentage: 100% of Actual Charge after the following Co-pay Amount per Policy Year:
  - Vision Care Examination: $25
  - Vision Care Examination for the covered service by the provider who furnishes it.

### Pediatric Dental Treatment Expense (Covered Persons under age 19 only)
- Covered Percentage: 50%
  - For Diagnostic and Preventive Services: $25
  - For Basic Services: $25
  - For Primary Services: $25
  - For Orthodontia: $25
  - For Oral Examination (Preventive): $25

### Medical Evacuation Expense
- Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the Company will pay for Eligible Expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Medical Evacuation, including reductions, if unreasonable to contact Travel Guard in advance.
- Not included are false labor, occasional spotting or medically necessary rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and pre-eclampsia, and similar conditions as severe as these.

### Definitions
- "Accident" means an occurrence which is unforeseen; (b) 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 Charge" means the charge for the covered service by the provider who furnishes it.
- "Complications of Pregnancy" means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
  - acute nephritis or nephrosis; or
  - cardiovascular decompensation or missed abortion; or
  - similar conditions as severe as these.
- "Coinsurance" means the percentage of the Eligible Expense payable by the Covered Person under the Policy.
“Co-pay” means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

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

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

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

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

“Dependent” means: (a) the Covered Student’s Spouse residing with the Covered Student; and (b) the Covered Student’s or Spouse’s child until the date such child attains age 26.

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

The “child” of a Covered Student or Spouse will not be denied enrollment under the Policy because he or she: 
(a) was born out of wedlock; 
(b) is not claimed as a dependent on the Covered Student’s or Spouse’s federal tax return; 
(c) does not reside with the Covered Student or Spouse in the Policy’s service area.

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

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

“Doctor” as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s Immediate Family Member.

“Durable Medical Equipment” consists of the following types of orthopedic or prosthetic devices or Hospital equipment: man-made limbs or eyes for the replacing of natural limbs or eyes; casts, splints or crutches; purchase of a truss or brace; oxygen and equipment for giving oxygen; wheelchair or hospital bed; dialysis equipment and supplies; colostomy bags and ureterostomy bags; two external post-operative breast prostheses, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: services, supplies, equipment, accessories or other items which can be purchased at retail establishments or otherwise over the counter without a Doctor’s prescription; adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

“Elective Treatment” means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person’s effective date of coverage.

Elective treatment includes, but is not limited to: vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities.

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

“Emergency Medical Condition” means a Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:
(a) the Covered Person’s life could be in serious jeopardy; 
(b) bodily functions would be seriously impaired; or 
(c) a body organ or part would be seriously damaged; or 
(d) serious disfigurement; or 
(e) serious jeopardy to the health of the fetus.

“Emergency Services” means, with respect to an Emergency Medical Condition:
(a) a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and 
(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

“Essential Health Benefits” has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Experimental/Investigational” means a drug, device or medical care or treatment that meets the following:
(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; 
(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law; 
(c) the drug, device, medical care or treatment or the patient’s informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval; 
(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is conducted to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or 
(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or...
treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis. Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

**“Hospital”** means a facility which meets all of these tests: (a) it provides in-patient services for the care and treatment of injured and sick people; and (b) it provides rooms 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 as an institution mainly rendering treatment or services for: mental or nervous disorders. The term “Hospital” includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; and (c) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

**“Hospital Confinement/Hospital Confined”** means a stay of at least 18 consecutive hours for which a room and board charge is made.

**Immediate Family Member(s)** means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

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

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

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

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

A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is Experimental/Investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Adminstration Medicare Coverage 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 Necessarily.

**“One Sickness”** means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

**“Orthopedic Brace and Appliance”** means a supportive device or appliance used to treat a Sickness or Injury.

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

**“Policy Year”** means the period of time measured from the Effective date to the Termination Date as shown in the Schedule of Benefits of the Policy.

**“Pre-Admission Testing”** means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person’s condition in anticipation of a scheduled Hospital Confinement and required prior to surgery; a Hospital bed and operating room have been reserved before the tests are made; Hospital Confinement begins within 3 days after the tests; and the Covered Person is physically present for the tests. In the event pre-admission testing is ordered by the attending Doctor and the Hospital Confinement and/or surgery are subsequently canceled, benefits for pre-admission testing and services already performed will be covered and benefits will be payable under the Policy based on the available coverage.

**“Preventive Services”** mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding early breast cancer screening, mammography and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

**“Reasonable and Customary”** means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

**“Geographic area”** means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date.

**“Sickness”** means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

**“Spouse”** means the Covered Student’s legal Spouse.

**“Student Health Service”** means any organization, facility or clinic owned, operated, maintained or supported by this Policyholder.

**“Urgent Care Provider”** means: (a) a freestanding medical facility which: (i) provides unscheduled medical services to...
treat an Urgent Condition; (ii) routinely provides ongoing unscheduled medical services for more than 8 consecutive hours; (iii) makes charges; (iv) is licensed and certified as required by any state or federal law or regulation; (v) keeps a medical record on each patient; (vi) provides an ongoing quality assurance program (this includes reviews by Doctors other than those who own or direct the facility); (vii) is run by a staff of Doctors, at least one of whom is on call at all times; (viii) has a full-time administra-
tor who is a Doctor; or (b) a Doctor’s office.

It is not the emergency room or outpatient department of a Hospital.

"Urgent Condition" means a sudden illness, Injury, or condition, that:

(a) is severe enough to require prompt medical attention to avoid serious deterioration of the Covered Person’s health;
(b) includes a condition which would subject the Covered Person to severe pain that could not be adequately managed without urgent care or treatment;
(c) does not require the level of care provided in the emergency room of a Hospital; and
(d) requires immediate outpatient medical care that cannot be postponed.

"Urgent Condition" includes, but is not limited to: small cuts or wounds that may require stitches; sprains, strains or deep bruises; mild to moderate asthma attacks; earaches or ear infections; upper respiratory infections; colds, coughs and congestion; diarrhea; sore throats; insect bites; headache; menstrual or muscle cramps; minor burns; minor swelling; sudden or chronic backache; dizziness; abdominal pains; and rashes.

Exclusions and Limitations.
The Policy does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment except as provided elsewhere in the Plan. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by this Policyholder’s Health Service, Infirmary or Hospital, or by health care providers employed by this Policyholder or services covered by the Student Health Services fee.
3. for eye examinations, eyeglasses, contact lenses, or prescriptions for such except as specifically provided in the Policy; radial keratotomy or laser surgery; hearing aids; or prescriptions or examinations for such except as required for repair caused by a covered injury. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids.
5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law.
8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. for cosmetic surgery. "Cosmetic surgery" shall not include reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible; or (c) as specifically provided for in the Policy. It also shall not include breast reconstructive surgery after a mastectomy.
11. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
12. for preventive treatment, testing, immunizations, injections, medicines, vaccines, vitamins antitoxins except as specifically provided in the Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
13. as a result of committing or attempting to commit an assault or felony or participation in a riot.
14. for Elective Treatment or elective surgery except as specifically provided.
15. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
16. for any services rendered by a Covered Person’s Immediate Family Member.
17. for any treatment, service or supply which is not Medically Necessary.
18. for personal items or services such as television, telephone or transportation.
19. for any treatment, service or supply which is not Medically Necessary.
20. for routine medical care physical examinations, health examinations or preschool physical examinations, well-baby care and related Doctor’s 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. by a Covered Person who is not a United States Citizen for services performed within the Covered Person’s home country if the Covered Person’s home country provides national health insurance.
22. for sterilization or sterilization reversal, including surgical procedures and devices except as specifically provided; or for birth control except as specifically provided.
23. for voluntary or elective abortions.
24. 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.
25. for rest cures or custodial care.
26. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
27. for Injury resulting from fighting, except in self-defense.
28. for treatment of obesity, including, but not limited to the following: gastric bypass, and any other restrictive proce-
    dure for weight loss; weight reduction or dietary control programs; prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complication resulting from weight loss treatments or procedures.
29. for breast reconstruction and implantation or removal of breast prostheses unless such care and services are per-
    formed solely and directly as a result of a Medically Necessary mastectomy.
30. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
31. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

32. for alternative health care, including but not limited to light therapy.

33. for hypnosis.

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 Plan for the same services or benefits covered by the settlement or judgment.

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

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 Plan 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, this Policyholder or the Covered Person. This provision will not apply if it is prohibited by law.

Travel Assist and Student Assist Services
Procedures on How to Access Travel Guard’s 24-Hour Assistance Call Center
How to Contact Travel Guard:
• Inside the US and Canada, dial 877-249-5362 toll-free.
• Outside the US and Canada: Request an international operator. Request the operator to place a collect call to the USA at 1-715-295-9625.
• Our fax number is 262-364-2203.

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

TravelGuard is available 24-hours-a-day/7-days-a-week/365-days-a-year
Our multi-lingual/multi-cultural Travel Assistance Coordinators (TAGs) 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, on-site Registered Nurses and Emergency Physicians who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a physician has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide Travel Guard when you call:
• Advise Travel Guard who you are insured by.
• 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 Guard 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 en route emergencies that force them to interrupt their trips.

• Legal Referral
• En route Travel Assistance
• Embassy/Consulate Information
• Claims-related Assistance
• Telephone Interpretation
• Lost/Stolen Luggage & Personal Effects Assistance
• 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 physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains and insurance claims coordination.

Medical assistance:
• Medical Referral
• In-patient Assistance
• Out-patient Assistance

Medical Transport:
• Medical 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 log on to: www.chartisinsurance.com/us/security. For initial setup, your login is “9497182” and the password is “security”. For more details visit the AIG, Educational Markets website at: http://studentinsurance.com/Schools/AL/TU/.

Privacy Policy
At Summit America Insurance Services, An Ascension Company, we know that your privacy is important to you, and we strive to protect the confidentiality of your non public personal information. We do not disclose any non public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 800-890-8755 or visiting us at www.summitamerica-ins.com.
Careington Dental: a Product of Careington International Corporation (Careington Dental is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)
Careington Dental is one of the nation’s leading dental care discount plans providing point-of-service savings at thousands of dental care facilities nationwide. The Careington Dental Discount Plan can help reduce your overall dental costs by taking advantage of discounts on exams, cleanings, fillings, crowns, root canals, dentures, braces and more.

THIS IS NOT INSURANCE.  
How To Use Your Discount Card:
1. Locate a provider by visiting the AIG, Higher Education website at http://www.studentinsurance.com/Schools/AL/TU/ to access the Careington Participating Providers under the Tuskegee University’s personalized web page. Then call the toll-free number at 1-800-441-0380 and have our Patient Advocate call to confirm provider participation and program fee schedule. Please note: The free eye exam benefit is subject to participating providers.
2. Present your member ID card at the time of your visit to the provider.
3. You are responsible for the total bill, less the applicable savings, at the time service is rendered.

Discount Vision Program through Vision Services Provider (VSP) (Not Affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)
Because you are currently a member of Script Care’s prescription drug program, you are also eligible to participate in the value-added Script Care Vision Program through VSP Vision Care. The discount vision program is available to all Script Care members at no additional cost and no premium. THIS IS NOT INSURANCE.  
How do members use the program?
1. There are thousands of participating provider locations nationwide. For a list of Providers near you, contact VSP Vision Care at 1-800-877-7195 or visit their website at www.vsp.com and click on the link to VSP Vision Care.
2. Locate a participating eye care provider. When you arrive at your appointment, show your Script Care ID card and receive a discount on eye exams. There are no claims to file, and there is no waiting for reimbursement.

New Directions Behavioral Health - SAP  
(New Directions Behavioral Health is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)
New Directions Behavioral Health provides you with a Student Assistance Program (SAP). New Directions will guide you with information, short-term counseling and when appropriate, connect you to additional resources. THIS IS NOT INSURANCE.

Your SAP provides up to three free confidential counseling sessions per issue per year. New Directions also offers a searchable health library on their website with hundreds of health and wellness resources. New Directions understands that having one part of your life out of balance can affect everything. As a student, you want to be your best. But when you have personal challenges, they can affect your school and home life. New Directions is available to assist you. They can assist with everyday issues, stress, emotions, family issues, relationship support, substance abuse and more.

The New Directions Behavioral Health SAP is available for your use 24/7/365.
1-800-624-5544
816-237-2352
www.ndbh.com
Log in code: Tuskegee

Online Services
Please visit our website at www.summitamerica-ins.com/Tuskegee for brochures, enrollment forms (printable using Adobe Acrobat), ID Cards, claims status and other services. For information on dental and vision plans that may be available, please call 1-800-890-8755 or visit the website at www.summitamerica-ins.com/Tuskegee.

Wellness - AIG Good4Me!
Find tips and other helpful information on important health topics, ranging from diet and exercise to managing stress.
Learn more about our Good4Me! solutions at www.studentinsurance.com.
Submit All Medical Claims to:
SUMMIT AMERICA INSURANCE SERVICES
PO Box 25936
Overland Park, KS 66225
Electronic Payer ID# 37301

Submit all Prescription Drug Claims Inquiries, and Eligibility Questions to:
Pharmacy network Information script Care, LTD
1-877-439-7344
www.scriptcare.com

Submit all Claims Inquiries, and Eligibility Questions to:
SUMMIT AMERICA INSURANCE SERVICES
PO Box 25936
Overland Park, KS 66225
www.summitamerica-ins.com
Call Toll Free (888) 580-2670, or
E-mail claims related questions to:
Claims@summitamerica-ins.com

SALES / MARKETING SERVICE:
Regions Insurance, Inc.
Jim Rowland, Senior Vice President
1901 6th Avenue North, Suite 1720
Birmingham, AL 35203
Phone: 205-264-4541
Fax: 205-264-7163
jim.rowland@regions.com

Tuskegee University
Medical/Rx ID Card
Bin Number: 004410
**Attention Providers: ask for Photo ID**
Pharmacy Help Desk 1-877-246-6997
"FirstHealth"
www.scriptcare.com

**Reverse Side Contains Medical Information**