Delaware College of Art & Design
(“the Policyholder”)

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

Administrator Policy Number: CHH8051776
Underwriter Reference Number: CAS9148821

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-DE. The Policy on file at the College contains all of the definitions, reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Policy. If any discrepancy exists between this brochure and the Policy, the Policy will govern. Travel Assistance services provided by Travel Guard Group, Inc. (“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.

Revised, 07/13/15
ELIGIBILITY

All full-time students registered at Delaware College of Art & Design for 9 or more credits will be automatically enrolled in and charged premium for coverage under the Delaware College of Art & Design Student Health Insurance Plan (“the Plan”) unless coverage under the Plan is waived by providing proof of comparable health insurance coverage by the waiver deadline of **August 14, 2015**. To waive coverage under the Plan, students must complete the online waiver form at [www.BollingerColleges.com/DCAD](http://www.BollingerColleges.com/DCAD). Students who do not waive coverage by the waiver deadline will be automatically billed for the insurance under the Plan and the premium will be added to their student account.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility under another creditable coverage. Proof of ineligibility under the other creditable coverage is required at time of enrollment. Contact Bollinger Specialty Group at 855-338-8015 for rates and enrollment information.

An eligible student must actively attend classes at the Policyholder’s school for the first 45 days of the period for which he or she is enrolled. Students who withdraw after such 45 days will remain covered under the Plan and no refund will be made. **Except in the case of full withdrawal from school due to Sickness or Injury,** any student withdrawing from school during the first 45 days of the period for which he or she is enrolled will not be covered under the Plan and a full refund of premium will be made less any claims paid. Home study, correspondence, Internet and television (TV) courses do not fulfill the Eligibility requirements that the student actively attended classes. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been met. If it is discovered that the Plan eligibility requirements have not been met, the Company’s only obligation is to refund premium less any claims paid.

EFFECTIVE AND TERMINATION DATES

The Policy on file with the Policyholder becomes effective at 12:01 a.m. on **August 25, 2015** and terminates at 11:59 p.m. on **August 24, 2016**.

The coverage of an eligible student, including a student who initially waived coverage and subsequently enrolls within 31 days of ineligibility under another creditable coverage, 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.

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:
  1) because of entering the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made within 30 days of leaving school); or
  2) when the withdrawal from school is during the first 45 days of the period for which the student is enrolled and is for a reason other than full 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 30 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 fully withdraw from the Policyholder’s school during the first 45 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.
COST OF INSURANCE*

<table>
<thead>
<tr>
<th>Term of Coverage</th>
<th>Annual 8/25/15-8/24/16</th>
<th>Spring/Summer** 1/16/16-8/24/16</th>
<th>Summer Only*** 5/31/16-8/24/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only</td>
<td>$1,500</td>
<td>$875</td>
<td>$337</td>
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</tbody>
</table>

*includes administrative fees  
**Spring/Summer-only coverage is available only to students new to the College in the Spring/Summer semester.  
***Summer-only coverage is available only to students new to the College in the Summer semester.

DEFINITIONS

“Accident” means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

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

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

“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

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

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

“Durable Medical Equipment” consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

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

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

“Eligible Expense” as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) with respect to the Preferred Provider, is the Allowable Charge; (d) is the negotiated rate, if any; and (e) incurred while the Policy is in force as to the Covered Person.
SECTION 2 – DEFINITIONS

“Emergency Medical Condition” means a medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

a) placing the health or pregnancy of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

b) serious impairment to such person’s bodily functions;

c) serious impairment or dysfunction of any bodily organ or part of such person;

d) serious disfigurement of such person.

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

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

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

“Experimental/Investigational” means a drug, device or medical care or treatment that meets the following:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;

(c) the drug, device, medical care or treatment or the patient’s informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;

(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

“Hospital” means a facility which meets all of these tests:

a) it provides in-patient services for the care and treatment of injured and sick people; and

b) it provides room and board services and nursing services 24 hours a day; and

c) it has established facilities for diagnosis and major surgery; and

d) it is supervised by a Doctor; and

e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and

f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.
SECTION 2 – DEFINITIONS

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) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

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

“Hospital Confinement/Hospital Confined” means a stay of at least 18 consecutive hours or 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.

“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.

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

“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.
SECTION 2 – DEFINITIONS

“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.

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

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

DELTA COLLEGE OF ART & DESIGN SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>ELIGIBLE EXPENSES</th>
<th>IN NETWORK</th>
<th>OUT OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate Maximum Amount per Policy Year</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

| Out-of-Pocket Limit per Covered Person per Policy Year  | $6,500     | $6,500        |

The Out-of-Pocket Limit will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit. 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; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy.

When the Out-of-Pocket Limit 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 for the remainder of that Policy Year up to any benefit maximum that may apply.

| Deductible Amount per Covered Person per Policy Year   | $2,000     | $2,000        |

INPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Daily Room and Board (average semi-private rate)</th>
<th>70% of AC</th>
<th>50% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Miscellaneous, 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.</td>
<td>70% of AC after a $250 copayment per confinement</td>
<td>50% of R&amp;C after a $250 copayment per confinement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-admission Testing (Hospital Confinement must occur within 3 days of the testing)</th>
<th>70% of AC</th>
<th>50% of R&amp;C</th>
</tr>
</thead>
<tbody>
<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>70% of AC</td>
<td>50% of R&amp;C</td>
</tr>
</tbody>
</table>

| Physiotherapy during Hospital Confinement | 70% of AC  | 50% of R&C    |
### Surgical Expense
- Assistant Surgeon: 70% of AC
- Anesthesia: 70% of AC

### In-Hospital Doctor’s Fees Expense
- 70% of AC

### Psychiatric Conditions Expense (Severe mental illness/mental and nervous disorders)
- Same as any other Sickness

### Alcoholism and Substance Abuse Expense
- Same as any other Sickness

### OUTPATIENT BENEFITS

<table>
<thead>
<tr>
<th>IN NETWORK</th>
<th>OUT OF NETWORK</th>
</tr>
</thead>
</table>
| Surgical Expense
  - Assistant Surgeon: 70% of AC
  - Anesthesia: 70% of AC |
| 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).
  - 70% of AC after a $250 copayment per visit
| Hospital Emergency Room and Non-Scheduled Surgery (for use of Hospital emergency room, including attending Doctor’s charges, operating room, laboratory and x-ray examinations, supplies)
  - The copayment amount will be waived if the Covered Person is admitted to the Hospital as an inpatient
| Preventive Services Benefit, as mandated by the Patient Protection and Affordable Care Act. To view a list of covered preventive services, go to http://www.healthcare.gov/preventive-care-benefits/
  - 100% of AC (applicable deductibles and copayments do not apply) |
| Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)
  - 70% of AC after a $30 copayment per visit |
| CAT Scan/MRI/PETScan
  - 70% of AC after a $30 copayment per visit |
| Radiation Therapy and Chemotherapy
  - 70% of AC after a $30 copayment per visit |
| Physiotherapy/Occupational Therapy
  - 70% of AC after a $30 copayment per visit and limited to 30 visits per Policy Year |
| Durable Medical Equipment (no benefits will be payable for rental charges in excess of the purchase price)
  - 70% of AC |
| Braces and Appliances
  - 70% of AC |
| 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 Benefits).
  - 70% of AC after a $30 copayment per visit |
<table>
<thead>
<tr>
<th>Service Type</th>
<th>In Network Coverage</th>
<th>Out of Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitative Services/Habilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>70% of AC after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
<td>50% of R&amp;C after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>70% of AC after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
<td>50% of R&amp;C after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>70% of AC after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
<td>50% of R&amp;C after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
</tr>
<tr>
<td>Cardiac/Pulmonary</td>
<td>70% of AC after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
<td>50% of R&amp;C after a $30 copayment per visit and limited to 30 visits per Policy Year</td>
</tr>
<tr>
<td>Speech and Hearing Therapy</td>
<td>70% of AC after a $30 copayment per visit</td>
<td>50% of R&amp;C after a $30 copayment per visit</td>
</tr>
<tr>
<td>Out of Hospital Doctor’s Fees Expense</td>
<td>70% of AC after a $30 copayment per visit</td>
<td>50% of R&amp;C after a $30 copayment per visit</td>
</tr>
<tr>
<td>Specialist’s</td>
<td>70% of AC after a $30 copayment per visit</td>
<td>50% of R&amp;C after a $30 copayment per visit</td>
</tr>
<tr>
<td><strong>OTHER BENEFITS</strong></td>
<td><strong>IN NETWORK</strong></td>
<td><strong>OUT OF NETWORK</strong></td>
</tr>
<tr>
<td>Ambulance Expense</td>
<td>70% of AC</td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>Dental Treatment Expense (Injury Only)</td>
<td>70% of R&amp;C</td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>Pediatric Dental Treatment Expense (for Covered Persons under age 19 only) subject to a $250 deductible per Policy Year.</td>
<td>70% of R&amp;C</td>
<td>70% of R&amp;C, 60% or R&amp;C, 50% of R&amp;C</td>
</tr>
<tr>
<td>• Preventive Services (limited to 1 oral exam every 6 months)</td>
<td></td>
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<tr>
<td>• Basic Services</td>
<td></td>
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<tr>
<td>• Major Services</td>
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<tr>
<td>• Orthodontic Services</td>
<td></td>
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<tr>
<td>See the complete Policy on file with the Policyholder for full details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed Medicines Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Percentage:</td>
<td>70% of Eligible Expenses after the applicable copayment amount:</td>
<td></td>
</tr>
<tr>
<td>Prescriptions must be filled at a Catamaran participating pharmacy. For a list of nationwide participating pharmacies, please visit <a href="http://www.studentinsurance.com">www.studentinsurance.com</a></td>
<td>$20 Generic copayment per prescription</td>
<td>$40 Brand Name copayment per prescription</td>
</tr>
<tr>
<td>Limited to a 30day supply per prescription or refill.</td>
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<tr>
<td>This benefit applies to all prescribed FDA-approved birth control methods. For prescribed FDA-approved birth control, the copayment will be waived and the benefit will be payable at 100%.</td>
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<tr>
<td>Psychiatric Conditions Expense</td>
<td>Same as any other Sickness</td>
<td>Same as any other Sickness</td>
</tr>
<tr>
<td>Service</td>
<td>Covered Percentage</td>
<td>Co-pay</td>
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<tr>
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<tr>
<td>Vision Care Expense – Limited to one exam and one pair of glasses (frames and lenses) per Policy Year (for Covered Persons age 19 and older)</td>
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<td></td>
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<tr>
<td>• Examination</td>
<td></td>
<td>$30 copayment per visit</td>
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<tr>
<td>• Materials</td>
<td></td>
<td>$50 copayment per visit</td>
</tr>
<tr>
<td>Standard Plastic Lenses:</td>
<td></td>
<td>60% of R&amp;C</td>
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<tr>
<td>Single Vision</td>
<td></td>
<td>Maximum Amount: $25</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td>$25</td>
</tr>
<tr>
<td>See the complete Policy on file with the Policyholder for full details.</td>
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<tr>
<td>Pediatric Vision Care Expense (for Covered Person under age 19)</td>
<td></td>
<td>$30 copayment per visit</td>
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<tr>
<td>Co-pay</td>
<td></td>
<td>$50 copayment per visit</td>
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<tr>
<td>• Examination</td>
<td></td>
<td>80% of R&amp;C</td>
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<tr>
<td>• Materials</td>
<td></td>
<td></td>
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<tr>
<td>Standard Plastic Lenses:</td>
<td></td>
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<tr>
<td>Single Vision</td>
<td></td>
<td>$25</td>
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<tr>
<td>Bifocal</td>
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<td>$25</td>
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<tr>
<td>Trifocal</td>
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<td>$25</td>
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<tr>
<td>Lenticular</td>
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<td>$25</td>
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<tr>
<td>Progressive</td>
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<td>$100</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td></td>
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<tr>
<td>Contact Lenses (in lieu of eyeglass lenses and frames)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit, Follow-up &amp; Materials:</td>
<td></td>
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<tr>
<td>-Effective</td>
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<td>$25</td>
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<tr>
<td>-Medically Necessary</td>
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<td>See the complete Policy on file with the Policyholder for full details.</td>
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<tr>
<td>Home Health Care Expense – limited to 100 visits per Policy Year</td>
<td></td>
<td>70% of AC</td>
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<td></td>
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<td>50% of R&amp;C</td>
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<td>Hospice Care Expense</td>
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<td>70% of AC</td>
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<td>50% of R&amp;C</td>
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<tr>
<td>Urgent Care Expense</td>
<td></td>
<td>70% of AC after a $50 copayment per visit</td>
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<td>50% of R&amp;C after a $50 copayment per visit</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td></td>
<td>70% of AC</td>
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<td></td>
<td></td>
<td>50% of R&amp;C</td>
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<tr>
<td>Maternity</td>
<td></td>
<td>Same as any other Sickness</td>
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<td>Same as any other Sickness</td>
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</table>
REPARTIATION OF REMAINS AND MEDICAL EVACUATION BENEFITS

REPARTIATION OF REMAINS: $10,000 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 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 these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions. Please see page 14 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

MEDICAL EVACUATION: $10,000 Maximum Amount

The Company will pay for eligible Medical Evacuation expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Medical Evacuation while outside his or her home country but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes. The Doctor ordering the Medical Evacuation must certify: (a) that the severity of the Covered Person’s Injury or emergency Sickness warrants his or her Medical Evacuation; and (b) the Covered Person has been Hospital Confined for at least five (5) consecutive days prior to Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions. Please see page 14 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Company will pay the benefit below for Injuries to a Covered Person: (a) caused by an Accident which happens while covered by the Plan; and (b) which directly, and from no other cause, result in any of the losses listed below within 90 days of the Accident that caused the Injury.

For Loss of      Maximum Amount
Life ................................. $10,000
Both Hands or Both Feet  .......... $10,000
Sight of Both Eyes............... $10,000
One Hand and One Foot............ $10,000
One Hand and the Sight of One Eye  $10,000
One Foot and the Sight of One Eye $10,000
One Hand or One Foot............... $ 5,000
The Sight of One Eye............... $ 5,000

“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.

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.
PPO PROVIDERS

A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. The PPO for the Plan is selected by the Company. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to policy provisions. A Covered Person has the option to use a PPO provider or a non-PPO provider. The PPO for Delaware College of Art and Design is PHCS Healthy Directions. To obtain a list of participating providers and hospitals, visit www.multiplan.com.

PREFERRED PROVIDER ORGANIZATION: PHCS HEALTHY DIRECTIONS
TOLL FREE TELEPHONE NUMBER: 800-678-7427

If a Covered Person seeks treatment from a nonparticipating provider, benefits will be reduced to the out of network Covered 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 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.

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

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

STATE MANDATED BENEFITS

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

COORDINATION OF BENEFITS

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

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.
3. For eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy; hearing aids; orthodontic braces and orthodontic appliances; or prescriptions or examinations for such. 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 commercial scheduled airline.
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 the Covered Person is entitled to benefits 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. It also shall not include breast reconstructive surgery after a mastectomy.
10. As a result of committing or attempting to commit an assault or felony or participation in a riot or insurrection.
11. For Elective Treatment or elective surgery or complications arising therefrom except as specifically provided in the Policy.
12. After the date insurance terminates for a Covered Person.
13. For any services rendered by a Covered Person’s Immediate Family Member.
14. For any treatment, service or supply which is not Medically Necessary.
15. As a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
16. For treatment of temporomandibular joint dysfunction.
17. For Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs while operating a motor vehicle.
18. For Injury or Sickness caused by, contributed to or resulting from the Covered Person’s use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage of or for the purpose as prescribed by the Covered Person’s Doctor.
19. For surgery and/or treatment of: acne; allergy, including allergy testing and anti-toxins; biofeedback-type services; circumcision; corns, calluses and bunions; deviated nasal septum, including submucuous resection and/or other surgical correction thereof except for purulent sinusitis; family planning except as specifically provided; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; impotence, organic or otherwise; learning disabilities; nonmalignant warts, moles and lesions; sleep disorders, including testing thereof; and vasectomy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
20. For routine medical care, 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.
21. As a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place, except in a Driver’s Education program.
22. For elective sterilization or its reversal, artificial insemination or in vitro fertilization.
23. For Injury resulting from travel in, or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle, bobsledding or bungee jumping.
24. For organ transplants except as specifically provided in the Policy.
25. For voluntary or elective abortions.
26. 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 activity, including travel to and from the activity and practice; scuba diving; hang gliding; parasailing; sky diving; flight in an ultra light aircraft; glider flying; sail planing; parachuting; or ballooning.
27. For rest cures or custodial care.
28. For treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
29. For treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
30. For treatment, service or supply for which a charge would not have been made in the absence of insurance.

CLAIM PROCEDURE

In the event of an Injury or Sickness, the Covered Person should:

1. Notify Bollinger Specialty Group within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as reasonably possible, by mailing a completed and signed claim form to Bollinger Specialty Group, PO Box 727, Short Hills, NJ 07078-0727.
2. Claim forms are available online at www.BollingerColleges.com/DCAD or by calling 1-866-267-0092. If the providers have given you bills, please keep a copy and attach them to the claim form.
3. Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Bollinger Specialty Group. Online claim status is available at www.BollingerColleges.com/DCAD or by calling 1-866-267-0092.
4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to Bollinger.
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 Center

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.

HOW TO CONTACT TRAVEL GUARD

Inside the US and Canada, dial 1-877-249-5362 toll-free.

Outside the US and Canada:

• Request an international operator.
• Request the operator to place a collect call to the USA at 1-715-295-9625.
• Our fax number is 1-262-364-2203.

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

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

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

• Advise Travel Guard of your insurance company name
• Provide your Underwriter Reference Number or School Name
• Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

Description of Services

General Information: Services listed below include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency, exchange rates, local Bank/Government holidays, and by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage and 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
• Embassy/Consulate Information
• Lost/Stolen Luggage & Personal Effects Assistance
• Lost Document Assistance
• Cash Transfer Assistance
• Enroute Travel Assistance
• Claims-related Assistance
• Telephone Interpretation
TRAVEL GUARD

DESCRIPTION OF TRAVEL ASSIST AND STUDENT ASSIST SERVICES (continued)

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.aig.com/travelguardassistance.

To register:
1. Click on “Sign In” in the upper right-hand corner.
2. Click on “Register Here”.
3. Enter the required information: first name, last name, email address, policy # 9148821 and then click “Submit”.

At AIG, Higher Education, 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 information, please go to our website at www.studentinsurance.com.

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Plan Administrator
Bollinger Specialty Group
1-800-526-1379

IFS Insurance
Ryan Dunn
1523 Concord Pike
Suite 301
Wilmington, DE 19803