



Wayne State University

("the Policyholder")

2016 – 2017 Student Health Insurance Plan For International Students

("the Plan")

Administrator Group Number: S214316

Underwriter Reference Number: CAS9151285

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

This brochure is only a brief description of the coverage available under policy series S30749NUFIC-PPO-MI (Rev. 1-16). The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file at the University. If any discrepancy exists between the contents of this brochure and the Policy, the Policy will govern in all cases. A copy of the Policy will be available to the Covered Student/Scholar in his or her online account at www.studentinsurance.com/schools/MI/Wayne or upon request. 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.



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CAMPUS HEALTH CENTER

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

ELIGIBILITY

All registered international students and scholars taking any amount of credit hours at Wayne State University are eligible for coverage under the Wayne State University Student Health Insurance Plan ("the Plan"). Eligible international students and scholars are required to enroll in the Plan by the appropriate enrollment deadline listed below. **An international student or scholar will not be permitted to attend classes at the University until he or she is enrolled under the Plan.** To enroll, eligible students and scholars can either log into their secure online account, or visit www.studentinsurance.com/schools/MI/Wayne/, select Wayne State University from the drop-down menu on the left hand side and follow the instructions; or if assistance is necessary, the student or scholar should contact the OISS Office located in the Welcome Center Building.

An eligible student or scholar must actively attend classes at the University for at least the first 30 days of the period for which he or she is enrolled. Students who withdraw after such 30 days will remain covered under the Plan and no refund will be made. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student or scholar status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

An eligible student or scholar may also enroll his or her eligible Dependents online by logging into his or her secure online account or by visiting www.studentinsurance.com/schools/MI/Wayne/ prior to the enrollment deadline noted below. An eligible Dependent is: (a) the Covered Student's or Scholar's Spouse residing with the Covered Student or Scholar; and (b) the Covered Student's or Scholar's or Spouse's child until the date such child attains age 26. A Dependent may become eligible for coverage under the Plan only when the student or scholar becomes eligible; or within 31 days of marriage, birth or adoption.

Enrollment Period Enrollment Deadline

Annual	10/17/16
Fall Only*	10/17/16
Winter Only**	01/27/17
Winter/Spring/Summer***	01/27/17
Summer Only****	07/03/17

*Fall Only coverage for students/scholars enrolled in the Fall semester only.

**Winter Only coverage for students/scholars new to the school in the Winter semester only.

***Winter/Spring/Summer coverage for students/scholars new to the school in the Winter/Spring/Summer semester only.

****Summer Only coverage for students/scholars new to the school in the Summer semester only.

2016-2017 STUDENT HEALTH INSURANCE PLAN COSTS*

	Annual 8/1/16–7/31/17	Fall Only (for students enrolled in the Fall semester only) 8/1/16–12/31/16	Winter Only (for students new to the school in the Winter semester only) 1/1/17–5/7/17	Winter/Spring/ Summer Only (for students new to the school in the Winter/Spring/Sum mer semester only) 1/1/17-7/31/17	Summer Only (for students new to the school in the Summer semester only) 4/1/17-7/31/17
Student/Scholar	\$1,276.00	\$550.00	\$455.00	\$751.00	\$441.00
Spouse	\$1,276.00	\$550.00	\$455.00	\$751.00	\$441.00
Each child**	\$1,276.00	\$550.00	\$455.00	\$751.00	\$441.00

*Plan costs include a University Administrative Fee

**Premium is charged per child, up to 3 times the premium fee, after which no further premium is charged for additional children.

EFFECTIVE AND TERMINATION DATES

The Policy becomes effective at 12:01 a.m. on August 1, 2016 and terminates at 11:59 p.m. on July 31, 2017.

The coverage of an eligible student or scholar who enrolls for coverage under the Policy shall take effect at 12:01 a.m. on the latest of the following dates:

1. the Policy Effective Date;
2. the day after the date for which the first premium for the Covered Student's or Scholar's coverage is received by the Company;
3. the date the Policyholder's term of coverage begins; or
4. the date the student or scholar becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder.

A covered Dependent's coverage shall take effect on the later the following dates: (1) the date the coverage for the Covered Student or Scholar becomes effective; or (2) the date the Dependent is enrolled for coverage, provided premium is paid when due.

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

- (a) the date the Policy terminates;
- (b) the last day for which any required premium has been paid; or
- (c) the date on which the Covered Student or Scholar withdraws from the University:
 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 the University); or
 2. when the withdrawal from the University is during the first 30 days of the period for which the student is enrolled (a full refund of premium will be made (less any claims paid) when written request is made within 30 days of leaving the University)..

If withdrawal from the University is for other than (1) or (2) above, no premium refund will be made. Students or Scholars will be covered for the Policy term for which they are enrolled and for which premium has been paid.

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

CERTIFICATE OF CREDITABLE COVERAGE

The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Policy is terminated. In addition, Certificates of Creditable Coverage shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time. In order to obtain a Certificate of Creditable Coverage, please contact Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, MA 01104 or call 877-657-5030. You may also log into your account to print the Certificate of Creditable Coverage at

www.studentinsurance.com/Schools/MI/Wayne/

NON-DUPLICATION OF COVERAGE

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

EXTENSION OF BENEFITS

If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the earliest of: (1) the date the Hospital Confinement ends; or (2) the end of the 30 day period following the date his or her coverage terminated.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

STATE MANDATED BENEFITS

The Plan covers all applicable state mandated benefits. Please see the Policy on file with the University for details or log into your secure student account at www.studentinsurance.com/schools/MI/Wayne/.

DEFINITIONS

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

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

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

“Complications of Pregnancy” means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; or
- eclampsia; puerperal infection; or
- RH Factor problems; or
- severe loss of blood requiring transfusion; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and pre-eclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy. Complications of Pregnancy also include:

- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion.)

“Coinsurance” means the percentage of the Eligible Expense payable by the Covered Person under the 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 Plan.

“Covered Person” means a Covered Student and his or her Dependents insured under the Policy.

“Covered Student” means a student of the Policyholder who is insured under the Policy. This definition also includes scholars, as defined by the Policyholder.

“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 end of the month 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 Michigan 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" 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: breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum; learning disabilities; and botox injections.

"Eligible Expense" means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury:

- (a) not in excess of the Reasonable and Customary charges; or
- (b) not in excess of the charges that would have been made in the absence of this coverage;
- (c) with respect to the Preferred Provider, is the Allowable Charge;
- (d) is the negotiated rate, if any; and
- (e) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the extension of benefits provision.

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

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

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

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

"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 or 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.

“Habilitative Services” means Medically Necessary health care services and health care devices that assist a Covered Person in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with a Covered Person’s environment. Examples of health care services that are not Habilitative Services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

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

- (a) it provides in-patient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
- (f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; (c) as a place for custodial or educational care; or (d) as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term "Hospital" includes: (a) 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.

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

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

A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Covered Person or provider; or
- (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
- (d) it is Experimental/Investigational or for research purposes; or
- (e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or
- (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
- (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

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

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

“Other Valid and Collectible Insurance” means any of the following group, group-type (such as, but not limited to franchise or blanket), family or individual coverages which provide benefits or services for, or because of, health care: (1) insurance policies; (2) subscriber contracts; (3) uninsured arrangements; (4) coverage through health maintenance organizations and other prepayment, group practice and individual practice plans; (5) medical benefits coverage in automobile “no-fault” and traditional automobile “fault” type contracts; and (6) coverage under a governmental plan or coverage required or provided by law; but not including: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

“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.

“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 Plan based on the available coverage.

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

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

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

“Reasonable and Customary” (“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.

“Sound Natural Teeth” means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

“Spouse” means the Covered Student’s or Scholar’s legal Spouse.

“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.

CAMPUS HEALTH CENTER REFERRAL

A referral from the Campus Health Center is required before benefits are payable. The referral requirement does not apply to the Covered Student's Dependent(s).

This provision does not apply if: (a) the Campus Health Center is closed; (b) covered service is rendered at another facility during school breaks or vacation times; (c) medical care is obtained by a student or scholar who is not eligible to use the Campus Health Center; (d) for mental and nervous disorders; (e) for annual routine gynecological/obstetrical services; or (f) for an Emergency Medical Condition. Furthermore, 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.

Per the Patient Protection and Affordable Care Act, if designation of a primary care physician is required, the Covered Person must be allowed to designate a physician who specializes in pediatrics as the child's primary care physician if the provider is in the network.

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

PREFERRED PROVIDER ORGANIZATION

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

Cofinity Website: www.cofinity.net

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

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

WAYNE STATE UNIVERSITY SCHEDULE OF BENEFITS

This Plan would satisfy the Gold Level – Actuarial Value 83.1%.

	IN-NETWORK	OUT-OF-NETWORK
Aggregate Maximum Benefit per Policy Year (all conditions combined)	Unlimited	
Deductible Amount *Referral required (See Campus Health Center Referral Section on page 9)	\$150 per Policy Year per Covered Person*	\$150 per Policy Year per Covered Person*
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 the Covered Person is responsible due to Covered Percentages being less than 100% reach the Out-of-Pocket Limit. The Out-of-Pocket Limit includes Deductibles, Co-payments and Coinsurance. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary (“R&C”); charges in excess of any specified maximum or charges incurred for any services not covered under the 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 or Scholar and his or her covered Dependents equals the Family Out-of-Pocket shown, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible Expenses incurred by such Covered Student or Scholar and his or her 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.	\$5,000 per Covered Person \$10,000 per Family	\$5,000 per Covered Person \$10,000 per Family
ELIGIBLE EXPENSES	IN-NETWORK	OUT-OF-NETWORK
INPATIENT BENEFITS		
Daily Room and Board Maximum (up to the average semi-private rate except if Intensive Care Unit)	80% of Allowable Charges	60% of R&C Charges
Miscellaneous Hospital Expense (includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays (including professional fees); oxygen tent, drugs, medicines (excluding take-home drugs); dressings; and other Medically Necessary and prescribed Hospital expenses)	80% of Allowable Charges	60% of R&C Charges
Maternity Care	Same as any other Sickness	Same as any other Sickness
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	80% of Allowable Charges	60% of R&C Charges
Pre-Admission Testing (Hospital Confinement must occur within 3 days of testing)	80% of Allowable Charges	60% of R&C Charges
Physiotherapy, occupational therapy, cardiac/pulmonary therapy during Hospital Confinement	80% of Allowable Charges	60% of R&C Charges
Surgical Expense	80% of Allowable Charges	60% of R&C Charges
Assistant Surgeon	80% of Allowable Charges	60% of R&C Charges

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Anesthesia	80% of Allowable Charges	60% of R&C Charges
In-Hospital Doctor's Fees Expense Includes consultant during Hospital Confinement when required and approved by attending Doctor. Includes evaluation and treatment for Eligible Expenses incurred for chronic pain	80% of Allowable Charges	60% of R&C Charges
Psychiatric Conditions Expense	Same as any other Sickness	Same as any other Sickness
Alcoholism and Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness
OUTPATIENT BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Surgical Expense	80% of Allowable Charges	60% of R&C Charges
Assistant Surgeon	80% of Allowable Charges	60% of R&C Charges
Anesthesia	80% of Allowable Charges	60% of R&C Charges
Day Surgery Facility/Miscellaneous When scheduled surgery is performed in a Hospital, outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines)	80% of Allowable Charges	60% of R&C Charges
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.)	80% of Allowable Charges	60% of R&C Charges
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	80% of Allowable Charges	80% of R&C Charges
Preventive Services includes Preventive Services such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act. To view a list of covered preventive services, log onto: www.healthcare.gov/preventive-care-benefits/ All Preventive Services that are available and rendered at the Student Health Center will be paid at 100%, not subject to Deductible, Co-pay Amounts or Coinsurance	100% of Allowable Charges, not subject to Deductible, Co-pay Amounts or Coinsurance	60% of R&C Charges
Allergy Testing	80% of Allowable Charges	60% of R&C Charges
Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)	80% of Allowable Charges	60% of R&C Charges
CAT Scan/MRI/PET Scan	80% of Allowable Charges	60% of R&C Charges
Radiation Therapy and Chemotherapy	80% of Allowable Charges	60% of R&C Charges
Durable Medical Equipment (No benefits will be payable for rental charges in excess of the purchase price.)	80% of Allowable Charges	60% of R&C Charges
Orthopedic Braces and Appliances (only upon a Doctor's written prescription)	80% of Allowable Charges	60% of R&C Charges
Injections and/or Immunizations (not otherwise covered under Preventive Services)	80% of Allowable Charges	60% of R&C Charges
Prosthetic Appliances and Devices	80% of Allowable Charges	60% of R&C Charges
Rehabilitative Services/Habilitative Services (Physiotherapy, occupational therapy, chiropractic, cardiac/pulmonary)	80% of Allowable Charges	60% of R&C Charges
Speech and Hearing Therapy	80% of Allowable Charges	60% of R&C Charges

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Dialysis and Filtration Procedures	80% of Allowable Charges	60% of R&C Charges
Infertility Services (Benefits are payable to diagnose cause of infertility, and services for or related to infertility treatment needed to correct an underlying cause of infertility. No coverage is available to Dependent Children.)	60% of Allowable Charges after a \$50 Co-pay per visit	40% of R&C Charges after a \$50 Co-pay per visit
Out of Hospital Doctor's Fees Expense (Includes routine physical examinations; TB skin tests and TSpot blood test when administered in the Doctor's office; infusion therapy; benefit for nutritional counseling; and evaluation and treatment for Eligible Expenses incurred for chronic pain.)		
Doctor (other than Specialist) Specialist	80% of Allowable Charges 80% of Allowable Charges	60% of R&C Charges 60% of R&C Charges
Consultant's Fees Expense	80% of Allowable Charges	60% of R&C Charges
Ambulance Expense	80% of Allowable Charges	60% of R&C Charges
Dental Treatment Expense (Injury to Sound Natural Teeth only)	80% of Allowable Charges	80% of R&C Charges
Dental Treatment Expense up to \$750 maximum per Policy Year, subject to a \$25 Deductible per Policy Year. Preventive Services Basic Services	80% of R&C Charges 50% of R&C Charges	80% of R&C Charges 50% of R&C Charges
See Policy on file with the Policyholder for details.		
Pediatric Dental Treatment Expense: (Covered Persons under age 20 only) Covered Percentage: For Diagnostic/Preventive Services (includes 2 oral exams and 3 cleanings (one procedure per 4 month period) per Policy Year) For Basic Services For Major Services (includes applicable dentures, endodontics) For Orthodontic Services For Oral Examination (Preventive)	100% of R&C Charges 80% of R&C Charges 50% of R&C Charges 50% of R&C Charges 100% of R&C Charges	
See Policy on file with the Policyholder for details.		
Dental Treatment Expense for Impacted Wisdom Teeth	80% of R&C Charges	80% of R&C Charges
Prescribed Medicine Expense Prescriptions must be filled at an OptumRx participating pharmacy. For the complete listing of providers, please go to www.optumrx.com (Limited to a 30-Day supply per prescription or refill) This benefit applies to all prescribed FDA-approved birth control drugs and devices, including over-the-counter contraceptives. The Co-pay and Deductible will not apply to prescribed FDA-approved birth control. Eligible Expenses include all FDA-approved smoking cessation medication including over-the-counter drugs for which there is a written order; and drugs prescribed by a Doctor	100% of R&C Charges after the appropriate Co-pay amount per prescription or refill: Generic: \$25 Formulary Brand Name: \$50 Non-Formulary Brand Drug: \$50 Specialty Brand Drug: \$50	
Elective Abortion Expense	80% of Allowable Charges	60% of R&C Charges
Psychiatric Conditions Expense	Same as any other Sickness	Same as any other Sickness
Alcoholism and Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness

<p>Vision Care Expense (for Covered Persons age 20 and over) limited to 1 set of lenses and frames per Policy Year Examination Materials Maximum Amount per Policy Year Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular Progressive Frames</p>	<p>\$25 Co-pay per visit \$75 Co-pay per visit Unlimited \$50 maximum \$50 maximum \$50 maximum \$50 maximum \$50 maximum \$100 maximum</p>	
<p>Pediatric Vision Care Expense (for Covered Persons under age 20 only) limited to 1 set of lenses and frames per Policy Year Examination Materials Maximum Amount per Policy Year Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular Progressive Frames</p>	<p>\$25 Co-pay per visit \$75 Co-pay per visit Unlimited \$50 maximum \$50 maximum \$50 maximum \$50 maximum \$50 maximum \$100 maximum</p>	
<p>Contact Lenses (In lieu of eyeglass lenses and frames Fit, Follow-up & Materials: Effective Medically Necessary</p>	<p>\$50 maximum \$50 maximum</p>	
Home Health Care Expenses	80% of Allowable Charges	60% of R&C Charges
Hospice Care Expenses	80% of Allowable Charges	60% of R&C Charges
TMJ Expense	Same as any other Sickness	Same as any other Sickness
Urgent Care Expenses (benefits are payable for the expenses incurred by a Covered Person for urgent care services rendered at an Urgent Care Center/Facility for treatment of an Urgent Condition)	80% of Allowable Charges	60% of R&C Charges
Skilled Nursing Facility Expense	80% of Allowable Charges, limited to 45 days per Policy Year	60% of R&C Charges, limited to 45 days per Policy Year
Human Organ and Tissue Transplant Expense	80% of Allowable Charges	60% of R&C Charges

ACCIDENTAL DEATH AND DISMEMBERMENT

Maximum Amount: \$10,000

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

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

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

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

REPATRIATION OF REMAINS/ EMERGENCY EVACUATION BENEFITS

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

If a Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person. Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance. Please see page 16 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

EMERGENCY EVACUATION BENEFIT - \$25,000 Maximum Amount

The Company will pay, subject to the Policy limitations, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Emergency Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Emergency Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes.

Travel Guard must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance. Please see page 16 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

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 Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy; hearing aids or prescriptions or examinations for such except as required for repair caused by a covered Injury. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery. "Cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
10. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins or anti-toxins except as specifically provided in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

11. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, illegal occupation, insurrection or civil commotion.
12. for Elective Treatment or elective surgery except as specifically provided in the policy.
13. after the date insurance terminates for a Covered Person except as may be specifically provided in the extension of benefits provision.
14. for any services rendered by a Covered Person's Immediate Family Member.
15. for any treatment, service or supply which is not Medically Necessary.
16. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
17. for surgery and/or treatment of: acne; biofeedback-type services; corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof unless due to Injury occurring while coverage is in force; hair growth or removal; impotence, organic or otherwise; premarital examinations; sexual reassignment surgery and related therapy; sleep disorders, including supplies, treatment and testing thereof. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
18. for routine physical examinations, health examinations or preschool physical examinations. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
19. 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.
20. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from professional and semi-professional sports; scuba diving; hang gliding; parachuting; or any other hazardous sport or hobby.
21. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
22. within the Covered Person's home country of domicile with respect to an international Covered Person.
23. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

EXCESS PROVISION

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same **Injury or Sickness**, on a provision of service basis or on an expense incurred basis under any Other Valid and Collectible Insurance. If the Other Valid and Collectible Insurance provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose policy or service contract has been in effect for the longer period of time at the date of such **Injury or Sickness**.

For purposes of the Policy, a Covered Person's entitlement to Other Valid and Collectible Insurance will be determined as if the Policy did not exist and will not depend on whether timely application for benefits from Other Valid and Collectible Insurance is made by or on behalf of the Covered Person.

Benefits under the Policy will be reduced to the extent that benefits for Expenses are covered by any Other Valid and Collectible Insurance whether or not a claim is made for such benefits.

SUBROGATION

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

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

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

If the Company exercises its rights under this provision, it will recover no more than the amount paid under the Policy for such benefits.

The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above.

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

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

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

“Third Party” means any person or organization other than the Company, the Policyholder or the Covered Person.

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

TRAVEL GUARD®

Description of Travel Assistance Services for Students

Wherever your travels may take you, in the event of a medical emergency or unexpected travel problem, Travel Guard is never more than a phone call away. Our state-of-the-art service centers deliver global service 24 hours a day, 7 days a week, 365 days a year.

How to contact Travel Guard:

Inside the United States and Canada, dial toll-free +1-877-249-5362

Outside the U.S. and Canada:

- Request an international operator.
- Request the operator to place a collect call to the U.S. at +1-715-295-9625.

Email us at assistance@aig.com

When to contact Travel Guard:

- If you require medical assistance or have a medical emergency.
- If you need assistance with a non-medical situation such as lost luggage, lost documents or other travel issues.

Helpful information to have available when you call Travel Guard:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

Travel Medical Assistance

From physician referrals to coordinating medical evacuations, we help traveling students address their medical needs with expediency and expert care:

- Coordinate medical evacuation arrangements
- Physician/hospital/dental/vision care referral details, when medical attention is required including assistance with appointments
- Coordination of repatriation arrangements for the return of mortal remains in accordance with local governmental procedures
- Assistance with emergency prescription replacement while abroad
- Dispatch of doctor or specialist
- In-patient and out-patient medical case management
- Arrangements of visitor to bedside of hospitalized insured
- Eyeglasses and corrective lens replacement assistance

General Travel Assistance

Flight delays, inclement weather, lost or stolen luggage and other travel hassles are an unfortunate reality of travel today. We keep traveling students on the move with a variety of travel assistance services:

- Lost or stolen documents assistance
- Embassy and consulate information and referrals
- Lost baggage search and luggage replacement assistance
- Emergency language interpretation and translation services
- Emergency return travel arrangements
- Flight and hotel re-bookings
- Immunization, visa and passport information
- Guaranteed hotel check-in
- Travel delay reports
- Emergency cash transfer assistance
- Legal referrals/bail bond assistance
- Foreign exchange, ATM and weather information
- Worldwide public holiday information
- Urgent message relay to family, friends or university associates

Travel Concierge Services

Whether it is finding local restaurants or concert tickets, our Concierge Desk is a direct line to a team of professional and personal assistants available to help your travels be more effective:

- Referrals for counselling services
- Restaurant or local activity assistance
- Recommendations for spring break
- Moving coordination assistance
- Locate laundry facilities, post offices or bus schedules
- Recommend local car maintenance assistance
- Concert and event ticketing
- Electronic and wireless device assistance
- Movie and theatre information and ticketing
- Assistance with locating low fuel prices
- Assistance with finding places to purchase room supplies
- Locating retail stores (including shopping, coffee shops with free wireless internet access)

Travel Assistance Website and Mobile App

You can access our secure website, an online resource to stay a step ahead with the latest travel, security and health information. Whether it's prior to travel, during the trip, or after the return home, our members-only assistance website provides student travelers access to in-depth travel, health and security information. You can connect to the travel assistance website from your computer, smartphone or tablet 24/7/365. Please visit www.aig.com/us/travelguardassistance for more information about the website and mobile app.

- Email alerts contain security developments, such as terror attacks, major strikes, disasters or disruptions and government warnings that may affect your travel destination(s) and specific travel dates.
- Country reports provide key information on political conditions, security issues, travel logistics and cultural considerations.
- The Travel Health section educates travelers on health-related concerns, precautions and requirements for destinations and ability to create personal travel health profiles.
- The Medical Translations tool translates medical terms and phrases into multiple languages.
- The Drug Brand Equivalency tool generates drug brand names and their equivalent names in multiple countries.
- Security Awareness Training provides online travel safety videos and knowledge tests provide basic tools and information to be an aware, organized and prepared traveler.

About AIG Travel and Travel Guard¹

AIG Travel, Inc., a member of American International Group, Inc., is a worldwide leader in travel insurance solutions and assistance. Travel Guard[®] is the marketing name for its portfolio of travel insurance solutions and travel-related services, including assistance and security services, marketed to both leisure and business travelers around the globe. Services are provided through a network of wholly owned service centers located in Asia, Europe and the Americas. For additional information, please visit our websites at www.aig.com/travel and www.travelguard.com.

CLAIM FILING PROCEDURES

Claims can be accepted directly from Doctors and medical facilities if the claim includes the name of the Covered Person, Covered Student's school name, date of services, diagnosis, treatment procedure and billed charges. Proof of loss must be furnished to the Company within 90 days after the date of such loss.

Claims can be submitted online at www.studentinsurance.com/Schools/MI/Wayne or mailed to the address below. If mailing, fill in the necessary information and mail all itemized medical and Hospital bills to the following address:

Consolidated Health Plans (EDI # 87843)
2077 Roosevelt Ave.
Springfield, MA 01104

Questions regarding benefits, specific claim information and periods of coverage should be directed to the address above or by calling the following Customer Service phone number: 877- 657-5030.

CLAIMS CUSTOMER SERVICE

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
Website: www.studentinsurance.com
1-877-657-5030

Questions regarding benefits, specific claim information and periods of coverage should be directed to the address above or by calling the following Customer Service phone number: 877-657-5030.

Visit www.studentinsurance.com/Schools/MI/Wayne/ to access the following functions:

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

At AIG, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more privacy information, please go to the website at www.AIG.com.

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