



# The University of South Carolina

(“the Policyholder”)

## 2016 – 2017 Student Health Insurance Plan

**Administrator Group Number:**

University of South Carolina (including School of Medicine and EPI Plans): S211916

**Underwriter Reference Number:**

University of South Carolina  
(other than the School of Medicine and EPI Plans): CAS9151258  
School of Medicine Plan: CAS9151260  
EPI Plan: CAS9151259

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

Consolidated Health Plans Customer Service

Questions: 1-877-657-5030 / Email: [usc@studentinsurance.com](mailto:usc@studentinsurance.com)

To waive/enroll: <http://www.studentinsurance.com/Apps/Schools/Default.aspx?Id=41>

This brochure is a general summary of the coverage under Policy Series S30749NUFIC-PPO-SC (Rev. 1-15). The Policy on file at the University contains all of the provisions, exclusions, limitations, definitions, and qualifications of your Plan benefits. If any discrepancy exists between this brochure and the Policy, the Policy will govern. A copy of the Policy will be available to the Covered Student in his or her online account at <http://studentinsurance.com/Apps/Schools/Default.aspx?ID=41> or upon request. The Plan also covers applicable Mandated Benefits as required by the State of South Carolina. 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](http://www.AIG.com).



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## ELIGIBILITY—VOLUNTARY ENROLLEES AND ENROLLMENT

The following students are eligible to enroll for coverage in the University of South Carolina Student Health Insurance Plan ("the Plan") on a voluntary basis if they are enrolled at the University of South Carolina ("the University") (including Regional campuses):

Students who are eligible to pay the Student Health Services health fee (if applicable); and

1. Students who are enrolled in a degree-seeking program; or
2. Students who are enrolled in a minimum of 6 semester hours; or
3. USC School of Medicine Students.

An eligible student may only enroll in the Plan under the following conditions:

- (a) during an initial or subsequent Open Enrollment Period; or
- (b) as a transfer student, within 31 days of the date of transfer; or
- (c) within 31 days of ineligibility under another creditable coverage plan (with appropriate documentation).

The Open Enrollment Periods end on **September 14, 2016 for the Annual/Fall coverage terms** and **February 5, 2017 for Spring/Summer coverage term**. An eligible student may insure himself or herself by going to <http://www.studentinsurance.com/Apps/Schools/Default.aspx?Id=41> and enrolling by the enrollment deadline.

## MANDATORY ENROLLEES AND WAIVERS

The following types of students are eligible and will be automatically enrolled in the Plan and the insurance premium will be added to their tuition bill each semester along with tuition and fees unless a waiver of coverage is submitted each semester online at <http://www.studentinsurance.com/Apps/Schools/Default.aspx?Id=41> showing proof of other insurance that meets the University's requirements before the waiver deadline:

1. All graduate students enrolled in nine (9) credit hours or more;
2. All graduate students with assistantships (GA, TA, LA, IA, etc.), regardless of enrolled credit hours; and
3. All international students, including students enrolled in the English Program for Internationals (EPI).

Waivers of coverage will only be accepted online, and no waivers will be accepted after the applicable waiver deadline date. In addition, a waiver of coverage must be submitted for each coverage term.

**The waiver deadlines for non-EPI students are as follows:**

Fall Coverage Term: September 14, 2016

Spring/Summer Coverage Term: February 5, 2017

**The waiver deadlines for EPI students are as follows:**

- Fall I Coverage Term: August 13, 2016
- Fall II Coverage Term: October 29, 2016
- Winter Coverage Term: January 21, 2017
- Spring Coverage Term: April 1, 2017
- Summer Coverage Term: June 10, 2017

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. An eligible student who experiences ineligibility under another creditable coverage, and who wishes to enroll in the Plan, must email proof of ineligibility to [qualifier@studentinsurance.com](mailto:qualifier@studentinsurance.com).

## ALL ELIGIBLE STUDENTS

An eligible student must actively attend classes at the University for at least the first 30 days of the period for which he or she is enrolled. 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. Premiums paid during an Open Enrollment Period are not pro-rated. 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.

Eligible students, other than EPI students, who are enrolled in the Plan, may also enroll their eligible Dependents (see definition of Dependent). A Dependent may become eligible for coverage under the Plan only when the student becomes eligible; or within 31 days of marriage, birth or adoption. A Covered Student may enroll his or her Dependents by completing the enrollment process at <http://www.studentinsurance.com/Apps/Schools/Default.aspx?Id=41> by the following enrollment deadline dates:

- **September 14, 2016 for Annual/Fall Semester**
- **February 5, 2017 for Spring/Summer Semester**

**Dependents must be enrolled in the same coverage term in which the Covered Student is enrolled.**

**Dependents of students enrolling in the EPI plan are not eligible for coverage under the Plan.**

## EFFECTIVE AND TERMINATION DATES

The Policies on file at the University becomes effective at 12:01 a.m. on the following dates:

- University of South Carolina (other than the School of Medicine Plan): August 1, 2016\*
- School of Medicine Plan: August 1, 2016
- EPI Plan: August 3, 2016

\*August 15, 2016 for students maintaining continuous coverage from the prior Policy Year.

The Policies on file at the University terminate at 11:59 p.m. on the following dates:

- University of South Carolina (other than the School of Medicine and EPI Plan): July 31, 2017
- School of Medicine Plan: July 31, 2017
- EPI Plan: August 2, 2017

## VOLUNTARY ENROLLEES

The coverage of an eligible student who enrolls for coverage under the Plan during an initial Open Enrollment Period or who enrolls for coverage within 31 days of the date of transfer to this Policyholder shall take effect at 12:01 a.m. on the latest of the following dates: (1) the Policy Effective Date; (2) the date for which the first premium for the Covered Student's 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.

The coverage of a student who enrolls for coverage under the Plan during any subsequent Open Enrollment Period shall take effect at 12:01 a.m. on the later of the following dates: (1) the date for which the premium for the Covered Student's coverage is received by the Company; or (2) the date this Policyholder's term of coverage begins.

However, a student who does not enroll himself or herself during an Open Enrollment Period may not apply for coverage until the next subsequent Open Enrollment Period unless application for coverage is made within 31 days of ineligibility under another creditable coverage plan. As a result of ineligibility under another creditable coverage plan, the student may enroll for coverage for himself or herself. In that case, the insurance for the eligible student becomes effective at 12:01 a.m. on the latest of the following dates: (1) the day after the date on which the first premium for the Covered Student's coverage is received by the Company; or (2) 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 on file with the Policyholder; or (3) the date the Company gives its written consent.

## MANDATORY ENROLLEES

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

## DEPENDENTS OF VOLUNTARY AND MANDATORY ENROLLEES

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

## ALL ELIGIBLE STUDENTS

**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); or
  2. when the withdrawal from school 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).

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

**NOTE: Except as specifically provided in the Policy, Dependent coverage expires concurrently with that of the Covered Student.**

## PPO PROVIDERS

For services rendered, Covered Persons insured under the Plan may choose to be treated within or outside of the Cigna PPO Network. Reimbursement rates will vary according to the source of care as described under the Plan Schedule of Benefits. Assignment of a Network Provider does not guarantee eligibility or right to student health benefits.

**It is the Covered Person's responsibility to verify that a provider is a Participating Provider prior to services being rendered.**

Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or the facility to which the Covered Person is referred is also a PPO provider.

For treatment or care received at a non-PPO provider because a PPO provider is not available, benefits for Eligible Expenses are payable at the PPO level.

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.

To locate a PPO Provider please call 1-877-657-5030 or visit <http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=41>.

## COORDINATION OF BENEFITS PROVISION

The Policy's Coordination of Benefits provision will be used to determine a Covered Person's benefits under the Plan if:

1. the person is insured for medical care benefits under the Plan and is also covered for these benefits under other plans; and
2. the benefits that would be paid by the Plan, without this provision plus the benefits that would be paid by the other plans, without a provision similar to this provision, would exceed allowed expenses.

## 2016 – 2017 STUDENT HEALTH INSURANCE PLAN COSTS

2016-2017 Student Health Insurance Non-EPI Plan Costs***	Annual *8/1/2016 - 7/31/2017 **8/1/16 – 7/31/17	Fall *8/1/2016-1/5/2017 **8/1/16 - 1/1/17	Spring/Summer *1/6/2017-7/31/2017 **1/2/17 - 7/31/17
Student	\$2,547.00	\$1,105.00	\$1,442.00
Spouse	\$2,547.00	\$1,105.00	\$1,442.00
Each Child****	\$2,547.00	\$1,105.00	\$1,442.00

\*University of South Carolina (other than the School of Medicine and EPI Plan)

\*\*School of Medicine Plan

\*\*\*The Student Health Insurance Plan costs include an administrative fee.

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

Monthly credit card drafts (Annual Enrollments Only) are also available online at

<http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=41>. Premiums paid within Open Enrollment Periods are not pro-rated.

2016-2017 Student Health Insurance EPI Plan Costs*	Fall I 8/3/16 – 10/15/16	Fall II 10/16/16 - 1/2/17	Winter 1/3/17 - 3/7/17	Spring 3/8/17- 5/15/17	Summer 5/16/17 - 8/2/17
Student Only	\$515	\$570	\$432	\$473	\$547

\*The Student Health Insurance Plan costs include an administrative fee.

## UNIVERSITY OF SOUTH CAROLINA SCHEDULE OF BENEFITS

This Plan would satisfy the Silver Level – Actuarial Value 78.7%.

ELIGIBLE EXPENSES	HEALTH CARE AT STUDENT HEALTH SERVICES (SHS)	HEALTH CARE IN-NETWORK	HEALTH CARE OUT-OF-NETWORK
Aggregate Maximum Benefit per Policy Year per Covered Person	UNLIMITED		
Deductible per Policy Year*: Per Covered Person Per Family *The Deductible Amounts do not apply to Eligible Expenses incurred at the SHS.	None None	\$750 3 times the Deductible per Covered Person	\$1,500 3 times the Deductible per Covered Person
Out-of-Pocket Limit per Policy Year: Per Covered Person Per Family	\$6,350 \$12,700	\$6,350 \$12,700	\$15,000 \$45,000

The Out-of-Pocket Limit is the maximum amount a Covered Person will pay for Eligible Expenses incurred during the Policy Year. 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; or charges in excess of any specified maximum or charges incurred for any services not covered under the Plan.

When this benefit becomes applicable to a Covered Person during a Policy Year, Eligible Expenses incurred in the remainder of that Policy Year will be payable at 100% up to any benefit maximum that may apply.

If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out-of-Pocket Limit, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible Expenses incurred by such Covered Student 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.

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INPATIENT	HEALTH CARE AT STUDENT HEALTH SERVICES (SHS)	HEALTH CARE IN-NETWORK	HEALTH CARE OUT-OF-NETWORK
Daily Room and Board Maximum limited to the average semi-private rate, except if Intensive Care Unit.	Not Applicable	80% of Allowable Charge	70% of Reasonable & Customary ("R&C")
Hospital Miscellaneous	Not Applicable	80% of Allowable Charge after a \$200 Co-pay per Hospital admission	70% of R&C after a \$300 Co-pay per Hospital admission
Pre-Admission Testing (Hospital Confinement must occur within 5 days of the testing)	Not Applicable	80% of Allowable Charge	70% of R&C
Physiotherapy, occupational therapy, cardiac/pulmonary therapy during Hospital Confinement, limited to one visit per day.	Not Applicable	80% of Allowable Charge	70% of R&C
Surgical Expense	Not Applicable	80% of Allowable Charge	70% of R&C
Assistant Surgeon	Not Applicable	80% of Allowable Charge	70% of R&C
Anesthesia	Not Applicable	80% of Allowable Charge	70% of R&C
In-Hospital Doctor's Fees Expense, limited to one visit per day. Includes consultant during Hospital Confinement when required and approved by attending Doctor.	Not Applicable	80% of Allowable Charge	70% of R&C
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.	Not Applicable	80% of Allowable Charge	70% of R&C
Psychiatric Conditions Expense Suicide, Attempted Suicide and Intentionally Inflicted Injury: Medically necessary inpatient services to treat medical emergencies resulting from such actions will be covered as an Emergency Medical Condition. (Medical Evacuation benefits resulting from attempted suicide or intentionally inflicted Injury will be considered under the Medical Evacuation Expense benefit.) Definitive treatment of any underlying mental health causal factors shall be covered under the Mental and Nervous Disorders benefits.	Not Applicable	Paid the same as any other Sickness	Paid the same as any other Sickness
Alcoholism and Substance Abuse Expense	Not Applicable	Same as any other Sickness	Same as any other Sickness
OUTPATIENT WITH SHS REFERRAL REQUIRED	HEALTH CARE AT STUDENT HEALTH SERVICES (SHS)	HEALTH CARE IN-NETWORK	HEALTH CARE OUT-OF-NETWORK
Surgical Expense	Not Applicable	80% of Allowable Charge	70% of R&C
Assistant Surgeon	Not Applicable	80% of Allowable Charge	70% of R&C
Anesthesia	Not Applicable	80% of Allowable Charge	70% of R&C
Day Surgery Facility/Miscellaneous	Not Applicable	80% of Allowable Charge after a \$150 Co-pay per visit	70% of R&C after a \$300 Co-pay per visit

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Hospital Emergency Room and Non-Scheduled Surgery (Co-pay waived if the Covered Person is admitted to the Hospital as an inpatient)	Not Applicable	80% of Allowable Charge after a \$450 Co-pay per visit	80% of R&C after a \$450 Co-pay per visit
Preventive Services mandated by the Patient Protection and Affordable Care Act (Please go to <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> to view a list of Preventive Services)	100% of Allowable Charge, not subject to Deductible, Co-pay Amounts, or coinsurance	100% of Allowable Charge, not subject to Deductible, Co-pay Amounts, or coinsurance for services not available at the SHS; otherwise, same as any other Sickness	Same as any other Sickness
Allergy Testing and Serum	Benefits include, but are not limited to, charges for the following: laboratory tests; Doctor's office visits, including visits to administer injections; prescribed medications for testing of the allergy, including equipment used in the administration of prescribed medication; and other Medically Necessary supplies and services. Such are Eligible Expenses and are payable as any other Sickness. Allergy serum is covered as a medical expense when it is not obtained under the Prescribed Medicines Expense. Allergy shots are covered under the Out of Hospital Doctor's Fees Expense.		
Laboratory and X-Ray Examinations (not otherwise covered under Preventive Services)	100% of Allowable Charge	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
CAT Scan/MRI and/or PET Scan	Not Applicable	80% of Allowable Charge after a \$150 Co-pay per visit	70% of R&C after a \$300 Co-pay per visit
Radiation Therapy and Chemotherapy	Not Applicable	80% of Allowable Charge	70% of R&C
Durable Medical Equipment (no benefits will be payable for rental charges in excess of the purchase price) and Orthopedic Appliance	Not Applicable	80% of Allowable Charge	70% of R&C
Orthopedic Braces and Appliances	Not Applicable	80% of Allowable Charge	70% of R&C
Prosthetic Appliances and Devices	Not Applicable	80% of Allowable Charge	70% of R&C
Rehabilitative Services/Habilitative Services			
Physiotherapy	100% of Allowable Charge after a \$20 Co-pay per visit	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Occupational Therapy	100% of Allowable Charge after a \$20 Co-pay per visit	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Chiropractic	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Cardiac/Pulmonary	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Dialysis and Filtration Procedures	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit

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Intravenous Home Therapy	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Speech and Hearing Therapy	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Respiratory Therapy, limited to one visit per day and does not apply when related to Doctor's visit.	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Injections and/or Immunizations (not otherwise covered under Preventive Services)	100% of Allowable Charge	80% of Allowable Charge	70% of R&C
Diagnostic Services and Medical Procedures performed by the Doctor (other than Doctor's visits, Physiotherapy, x-rays and lab procedures), including Sickle Cell Anemia Testing (not otherwise covered under Preventive Services)	100% of Allowable Charge	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Chiropractic Services (not otherwise covered under Essential Health Benefits)	Not Applicable	80% of Allowable Charge	70% of R&C
Diagnosis and Treatment of Sleep Disorders	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Wellness Services (not otherwise covered under Preventive Services), not subject to the Deductible. Coverage includes services that promote health and well-being not otherwise covered under this Policy, but is not limited to, routine Doctor's visits, routine physical examinations, diagnostic tests and procedures, routine testing, screenings, and services related to routine physical examinations, testing for ADD and ADHD, TB skin tests and TSpot blood test.	100% of Allowable Charge, limited to \$500,000 per Policy Year	100% of Allowable Charge, limited to \$500,000 per Policy Year	70% of R&C, limited to \$500,000 per Policy Year
Out of Hospital Doctor's Fees Expense, including infusion therapy (benefits do not apply when related to surgery or Physiotherapy)			
Doctor (other than Specialist)	100% of Allowable Charge after a \$20 Co-pay per visit	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Specialist	100% of Allowable Charge after a \$20 Co-pay per visit	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Consultant's Fees Expense	Not Applicable	80% of Allowable Charge after a \$25 Co-pay per visit	70% of R&C after a \$40 Co-pay per visit
Ambulance Expense	Not Applicable	80% of Allowable Charge	80% of R&C

<p>Dental Treatment Expense (for Covered Persons age 19 and older)</p> <p><b>Preventive Services:</b></p> <ul style="list-style-type: none"> <li>• Oral Exam – limited to 2 per Policy Year</li> <li>• Bitewing – limited to 1 procedure per Policy Year</li> <li>• Biopsy of Oral Tissue</li> <li>• Prophy – Adult – limited to 1 procedure per 6 month period</li> </ul> <p><b>Basic Services:</b></p> <ul style="list-style-type: none"> <li>• One surface amalgam – permanent</li> <li>• Two surface amalgam – permanent</li> <li>• Three surface amalgam – permanent</li> <li>• Four surface amalgam – permanent</li> </ul> <p><b>For details, see the Policy on file with the Policyholder.</b></p>	<p>Not Applicable</p>	<p>100% of R&amp;C</p> <p>80% of R&amp;C</p>	
<p>Pediatric Dental Treatment Expense (for Covered Persons under age 19)</p> <p>Preventive Services Basic Services Major Services Orthodontic Services</p> <p><b>For details, see the Policy on file with the Policyholder.</b></p>	<p>Not Applicable</p>	<p>100% of R&amp;C 50% of R&amp;C 50% of R&amp;C 50% of R&amp;C</p>	
<p>Dental Treatment Expense For Injury and Impacted Wisdom Teeth:</p> <p>Injury to Sound Natural Teeth Removal of impacted wisdom teeth</p>	<p>Not Applicable</p>	<p>80% of R&amp;C, limited to \$1,000 per Policy Year 80% of R&amp;C, limited to \$1,000 per Policy Year</p>	
<p>Second Surgical Opinion Expense</p>	<p>Not Applicable</p>	<p>80% of Allowable Charge after a \$25 Co-pay per visit</p>	<p>70% of R&amp;C after a \$40 Co-pay per visit</p>
<p>Prescribed Medicines Expense – Co-pay per prescription, limited to a 30 day supply.</p> <p>Prescribed Medicines Expense benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person's Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic, plus the brand name Co-pay.</p> <p>This benefit applies to all prescribed FDA-approved birth control methods. Benefits for prescribed FDA-approved birth control methods will be based on the generic formulary unless a generic drug or device is not available or the Doctor indicates "dispense as written" on the prescription. The Co-pay, Deductibles and Covered Percentage do not apply to prescribed FDA-approved birth control.</p> <p>Eligible Expenses for outpatient contraceptive services will be included in Preventive Services</p>	<p>80% of R&amp;C after a \$10 Co-pay per prescription.</p>	<p>After a \$100 additional Deductible per Policy Year, 80% of R&amp;C after the applicable Co-pay amount:</p> <p>Generic - \$20 Formulary Brand Name - \$40 Non-Formulary Brand Drug - \$100 Specialty Brand Drug – 25% of charges with a \$200 minimum - \$500 maximum</p> <p>Pharmacy services provided by Cigna Rx: The Covered Person should present his or her insurance card at Participating Pharmacies to obtain prescriptions (see detailed benefit information at <a href="http://www.studentinsurance.com">www.studentinsurance.com</a>) For Pharmacy Help Desk please call 1- 800-325-1404.</p>	

<p>Psychiatric Conditions Expense</p> <p>Suicide, Attempted Suicide and Intentionally Inflicted Injury: Medically necessary outpatient services to treat medical emergencies resulting from such actions will be covered as an Emergency Medical Condition. (Medical Evacuation benefits resulting from attempted suicide or intentionally inflicted Injury will be considered under the Medical Evacuation Expense benefit.) Definitive treatment of any underlying mental health causal factors shall be covered under the Mental and Nervous Disorders benefits.</p>	Not Applicable	Same as any other Sickness	Same as any other Sickness
<p>Alcoholism and Substance Abuse Expense</p>	Not Applicable	Same as any other Sickness	Same as any other Sickness
<p>Vision Care Expense (for Covered Persons age 19 and older), limited to \$300 per Policy Year</p> <p>Examination</p> <p>Materials</p> <p>Benefits are limited to one examination, one pair of lenses, and one frame per Policy Year.</p>	Not Applicable	100% of R&C after a \$20 Co-pay per visit 100% of R&C after a \$20 Co-pay per visit	
<p>Pediatric Vision Care Expense (for Covered Persons under age 19)</p> <p>Examination</p> <p>Materials</p> <p>Standard Plastic Lenses:</p> <p>    Single vision</p> <p>    Bifocal</p> <p>    Trifocal</p> <p>    Lenticular</p> <p>    Progressive</p> <p>Frames</p> <p>Benefits are limited to one examination, one pair of lenses, and one frame per Policy Year.</p>	Not Applicable	100% of R&C after a \$20 Co-pay per visit 100% of R&C after a \$20 Co-pay per visit Maximum Amount: \$150 \$150 \$150 \$150 \$150 \$150	
<p>Home Health Care Expense</p>	Not Applicable	80% of Allowable Charge, limited to 60 visits per Policy Year	70% of R&C, limited to 60 visits per Policy Year
<p>Hospice Care Expense</p>	Not Applicable	80% of Allowable Charge	70% of R&C
<p>Urgent Care Expense</p>	Not Applicable	80% of Allowable Charge after a \$75 Co-pay per visit	70% of R&C after a \$75 Co-pay per visit
<p>Skilled Nursing Facility</p>	Not Applicable	80% of Allowable Charge after a \$200 Co-pay per confinement	70% of R&C after a \$300 Co-pay per confinement

**To receive benefits, Covered Students and their Spouses must first visit the student Health service for treatment / referral. Exceptions are listed under “Referrals”.**

## REFERRALS

A referral from the Student Health Service is required before benefits are payable. This referral requirement does not apply to the Covered Student's Dependent children.

This provision does not apply if: (a) the Student Health Service is closed; (b) covered service is rendered at another facility during school breaks or vacation times; (c) medical care is received when student is more than 30 miles from campus; (d) medical care is obtained by a student who is not eligible to use the Student Health Service; (e) for maternity; (f) for mental disorders; or (g) for an Emergency Medical Condition; however, the student must return to the Student Health Service for necessary follow-up care. Additionally, no authorization or referral requirement shall apply to obstetrical or gynecological care provided by in-network providers.

**Benefits for Eligible Expenses incurred for medical care or treatment rendered for which a referral is required but not obtained will be excluded from coverage.** Benefits for an Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or Non-PPO provider.

The applicable Deductibles, Coinsurance and Co-pay amounts shall apply to all of the exceptions to the referral requirement shown above.

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.

## REPATRIATION OF REMAINS AND MEDICAL EVACUATION

### COMBINED MAXIMUM LIMIT OF \$1,000,000

#### REPATRIATION OF REMAINS

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 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 18 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

#### MEDICAL EVACUATION

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 any Medical 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 18 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

## STATE MANDATED BENEFITS

This Plan also covers applicable Mandated Benefits as required by the State of South Carolina. For details, see the Policy on file within your student account at <http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=41>.

## PLAN EXCLUSIONS AND LIMITATIONS

Notwithstanding any provision of the Plan to the contrary, if the Plan generally provides benefits for any type of Injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health condition), even if the medical condition is not diagnosed before the Injury.

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

1. for services normally provided without charge by this Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by this Policyholder or services covered by the Student Health Service fee.
2. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided; radial keratotomy or laser surgery. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
3. for hearing examinations or hearing aids except as specifically provided.
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 to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible; or (c) as specifically provided for in the Policy. It also shall not include breast reconstructive surgery after a mastectomy.
10. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins anti-toxins except as specifically provided in the Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
11. as a result of committing or attempting to commit an assault or felony or participation in a riot, 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. for surgery and/or treatment of: acne; acupuncture; gynecomastia; biofeedback-type services; breast implants; or breast reduction unless Medically Necessary following a mastectomy; circumcision; deviated nasal septum, including submucuous resection and/or other surgical correction thereof except for purulent sinusitis; fertility tests; infertility(male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; nonmalignant warts, moles and lesions; premarital examinations; sexual reassignment surgery; vasectomy; alopecia. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
17. for patient controlled analgesia (PCA).
18. for artificial insemination or in vitro fertilization.
19. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle); or bungee jumping.
20. for elective abortions.
21. for chiropractic care or treatment not related to the treatment of Injury or Sickness except as specifically provided.
22. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports activity, including travel to and from the activity and practice; sporting events; racing or speed contests; hang gliding; parasailing; sky diving; glider flying; sail planing; parachuting.
23. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
24. for Injury resulting from fighting, except in self-defense.
25. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
26. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

## PLAN 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).

**“Actual Charge”** means the charge for the covered service by the provider who furnishes it.

**“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 Plan.

**“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 Dependent(s) insured under the Plan.

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

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

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

The term "child" includes:

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

The “child” of a Covered Student or Spouse will not be denied enrollment under the Plan 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 Plan'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 Plan;
- (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 Plan is required to provide coverage by the South Carolina 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 Plan but fails to apply to insure the child in accordance with the court or administrative order, such child will become insured on the date the Company receives the written request

to insure the child from the child's other parent, the state agency administering the Medicaid program or the state agency administering the Child Support Enforcement program.

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

**"Durable Medical Equipment"** consists of, 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; botox injections.

**"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 Plan is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

**"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (b) serious impairment to bodily functions; or
- (c) 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 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 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.

**"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. The term "Hospital" includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; and (c) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

**"Hospital Confinement/Hospital Confined"** means a stay of at least 18 consecutive hours 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.

**"Open Enrollment Period"** means the time period designated by this Policyholder during which the Student may enroll himself or herself and his or her Dependents for coverage under the Plan.

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

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

**"Policy Year"** means the period of time measured from 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.

**"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 5 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"** 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 legal Spouse. The term "Spouse" wherever used in the Policy shall also mean the Covered Student's same sex domestic partner with whom a domestic partnership has been established attesting to the relationship with another person, providing they are living together and any applicable requirements regarding domestic partnership interdependency have been met. A domestic partnership qualifies if the partners are able to provide a domestic partnership certificate from a city, county or state which offers the ability to register a domestic partnership.

The domestic partnership must satisfy the following requirements:

1. registration as a domestic partnership or, in the case of retirees living outside the City, an alternative affidavit of domestic partnership;
2. proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
3. evidence of two or more of the following:
  - (a) a joint bank account;
  - (b) a joint credit card or charge card;
  - (c) joint obligation on a loan;
  - (d) status as an authorized signatory on the partner's bank account, credit card or charge card;
  - (e) joint ownership; of holdings or investments;
  - (f) joint ownership of residence;
  - (g) joint ownership of real estate other than residence;
  - (h) listing of both partners as tenants on the lease of shared residence;
  - (i) shared rental payments of residence (need not be shared 50/50);
  - (j) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
  - (k) a common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
  - (l) shared household budget for purposes of receiving government benefits;
  - (m) status of one as representative payee for the other's government benefits;

- (n) joint ownership of major items of personal property (e.g., appliances, furniture);
- (o) joint ownership of a vehicle;
- (p) joint responsibility for child care (e.g., school documents, guardianship);
- (q) shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- (r) execution of wills naming each other as executor and/or beneficiary;
- (s) designation as beneficiary under the other's life insurance policy;
- (t) designation as beneficiary under the other's retirement benefits account;
- (u) mutual grant of durable power of attorney;
- (v) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- (w) affidavit by creditor or other individual able to testify to partners' financial interdependency;
- (x) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

## TRAVEL GUARD<sup>®</sup>

### 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](mailto: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.com](http://www.aig.com/us/travelguardassistance.com) 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 Guard®

AIG Travel, Inc., a member of American International Group, Inc., is a worldwide leader in travel insurance solutions and assistance. Travel Guard<sup>®</sup> 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](http://www.aig.com/travel) and [www.travelguard.com](http://www.travelguard.com).

## CLAIMS 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 must be submitted to:

### **Cigna**

PO Box 188061  
Chattanooga, TN 37422-8061  
Cigna Payer ID: 62308

Questions regarding benefits, specific claim information and periods of coverage should be directed to the above address or the following Consolidated Health Plans Customer Service phone number: 1-877-657-5030

## PRE-NOTIFICATION RECOMMENDED

The Covered Person should report to the Company all inpatient admissions to a Hospital, including length of stay, and all surgical procedures performed in an outpatient facility or ambulatory surgical center that require general anesthesia. To report an inpatient or outpatient service call 1-877-657-5030. Pre-Notification is not a guarantee that benefits will be paid.

## PHARMACY HELP DESK

For Pharmacy and prescription help please call 1 800-325-1404. To obtain a formulary listing (including prior approval prescription drugs), visit [www.studentinsurance.com](http://www.studentinsurance.com), search for your institution and click on "Pharmacy".

## CREDITABLE COVERAGE

The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Plan 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 Plan. Such issuance will occur within a reasonable time. In order to obtain a Certificate of Creditable Coverage please contact Consolidated Health Plans at 1-877-657-5030 or log into your secure online account and request your certificate. The Certificate of Coverage will then be made available through the Covered Student's secure online account.

## EXTENSION OF BENEFITS

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

If a Covered Person is undergoing outpatient treatment for an Emergency Medical Condition on the termination date, Eligible Expenses shall include charges incurred for that Emergency Medical Condition, but only while they are incurred during the 30 day period following such termination of insurance, subject to the applicable Maximum Amounts of the Policy.

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.

## 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 this 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 this Policy are sought and to notify the Company of his or her decision within such 30 day period.

If the South Carolina Director of Insurance, upon petition by the Covered Person, determines that the exercise of subrogation by the Company is inequitable and commits an injustice to the Covered Person, subrogation under this provision will not be allowed. This determination by the South Carolina Director of Insurance or his designee may be appealed to the Administrative Law Judge Division, as provided by law in accordance with §38-71-190.

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 this 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. Attorney's fees and cost will be paid by the Company from any amounts recovered on behalf of the Covered Person.

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

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

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

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

## **ASK MAYO – NURSELINE**

(Ask Mayo is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

Choosing the right level of care can help you save time, money and possibly your life. Contact Ask Mayo Clinic anytime, anywhere – day or night, when your doctor's office is closed, from the comfort of your home or when you are traveling.

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free 844-886-2896.

Ask Mayo is not a substitute for emergency response systems. In a medical emergency, you should call 911 or your local emergency number. Ask Mayo Clinic nurses do not answer health plan benefit questions. If you have questions about benefits of claims, please call your health plan's customer service department.

## **CLAIMS ADDRESS**

Cigna  
PO Box 188061  
Chattanooga, TN 37422-8061  
Cigna Payer ID: 62308

## **CLAIMS QUESTIONS**

Consolidated Health Plans  
2077 Roosevelt Ave.  
Springfield, MA 01104  
1-877-657-5030

## **STUDENT HEALTH INSURANCE**

Website: [www.studentinsurance.com](http://www.studentinsurance.com)

E-mail: [usc@studentinsurance.com](mailto:usc@studentinsurance.com)

## ONLINE SERVICES

(A secure site for all of your insurance needs) Go online at [www.studentinsurance.com](http://www.studentinsurance.com)

Search for your Institution

On this secure site you can:

- Enroll
- Waive Coverage
- Print ID Card
- Enroll Dependents
- Update your personal information
- Search for Providers and Hospitals
- View a Summary of Benefits
- View claims information / EOB's
- Take a Survey
- Join Red Alerts When Traveling
- Access the Mobile Experience

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 information, please go to our website at [www.AIG.com](http://www.AIG.com).

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