Houston Community College
("the Policyholder")

2016 - 2017
Student Health Insurance Plan for International Students
("the Plan")

Administrator Group Number: S216016
Underwriter Reference Number: CAS 9151584

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

Please keep this brochure as a general summary of the insurance. This brochure is only a brief description of the coverage available
under policy series S30749NUFIC-PPO-TX (Rev 4-16). The Policy on file at Houston Community College contains all of the definitions,
reductions, limitations, exclusions and termination provisions. If there is any conflict between the contents of this brochure and the
Policy, the Policy shall 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=322 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.

Revised 9/14/2016
PROGRAM OVERVIEW

This brochure provides a brief description of the International Student Health Insurance Plan for eligible international students at Houston Community College. The Policy on file with the College contains complete details of the coverage and is the governing document. Inspection of the Policy may be made during business hours at the Office of International Student Service. A copy of the Policyholder’s Policy is also on file within the Covered Student’s online account at http://studentinsurance.com/Apps/Schools/Default.aspx?ID=322.

ELIGIBILITY

All international students holding an “F-1” visa and enrolled for a minimum of nine (9) credit hours at Houston Community College will be automatically enrolled in and billed each semester for coverage under the Plan unless a waiver of coverage has been submitted and approved online at www.studentinsurance.com/Apps/Schools/Default.aspx?ID=322 by the waiver deadline date each semester. The waiver deadline dates are as follows: Fall: 9/19/16; Spring/Summer: 2/13/17 and Summer Only: 6/5/17. Waiver procedures are available online at www.studentinsurance.com/Apps/Schools/Default.aspx?ID=322. NOTE: No waivers will be accepted after the waiver deadline date.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage plan may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility under another creditable coverage. Proof of ineligibility under another creditable coverage is required at the time the enrollment form is submitted. For more information, an eligible student should contact Consolidated Health Plans at 1-877-657-5030

An eligible student must actively attend classes at the College for at least the first 45 days of the period for which he or she is enrolled. Students who fully withdraw after such 45 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 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.

PLAN COSTS AND COVERAGE PERIODS

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Fall</th>
<th>Spring/Summer</th>
<th>Summer Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*8/22/16 to 1/16/17</td>
<td>1/17/17 to 8/21/17</td>
<td>(new students to the College in the Summer only) 6/5/17 to 8/21/17</td>
</tr>
<tr>
<td>Student Only</td>
<td>$790</td>
<td>$1,149</td>
<td>$409</td>
</tr>
<tr>
<td>*8/24/16 for students maintaining continuous coverage from the previous policy period</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLAN YEAR

The Plan commences at 12:01 a.m. on August 22, 2016* and terminates at 11:59 p.m. on August 21, 2017.

*August 24, 2016 for students maintaining continuous coverage from previous policy period.

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, 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 College.

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, subject to the grace period; 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 the College is during the first 45 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); or (3) because of departure from the College for his or her home country (premiums will be refunded on a pro-rata basis (less any claims paid) only upon written proof from the College that the Covered Student is no longer an eligible person).

If withdrawal from the College is for other than (1), (2) or (3) 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.
EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled as a result of Sickness or Injury on the date the Plan terminates, Eligible Expenses shall include charges incurred for the treatment of that Sickness or Injury, but only until the earliest of: (1) the end of the Sickness or Injury that caused the Total Disability; (2) the end of a 90 day period following the date the Plan terminates; or (3) the date the applicable Maximum Amount is reached.

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

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

CONFORMITY WITH STATE STATUTES

Any provision of the Policy or this brochure which is in conflict with the statutes of the state in which the Policy is delivered or issued for delivery is amended to conform with the requirements of those state statutes.

COORDINATION OF BENEFITS

The Plan will coordinate benefits with any valid collectible insurance or plan as outlined in the Policy, which is available at the Office of International Student Services.

STATE MANDATED BENEFITS


PREFERRED PROVIDER ORGANIZATION (PPO) CIGNA NETWORK

Please note that the PPO network for the Plan is Cigna Network.

The Plan has incorporated into the coverage access to the Cigna Network of Hospitals and Doctors (PPO), which is the Preferred Provider Organization for the Plan. A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. Coverage is available nationwide for Eligible Expenses incurred at 80% of Allowable Charges (AC) when treated by network providers (PPO) and 60% of Reasonable and Customary (R&C) charges when treated by non-network providers (Non-PPO). However, if such treatment is received by a Non-PPO provider or facility because of an Emergency Medical Condition, benefits for Eligible Expenses are payable at the PPO level.

For a complete listing of PPO Hospitals and Doctors, visit www.cigna.com.

If a Covered Person is referred by a PPO provider to another facility, it does not mean that the provider or facility to which he/she is referred is also a PPO provider. For instance, when a network provider refers a Covered Person to a lab for tests, he/she should be sure it is a network lab.
# HOUSTON COMMUNITY COLLEGE – SCHEDULE OF BENEFITS

## Student Health Insurance Plan for International Students

THIS PLAN WOULD SATISFY THE GOLD LEVEL – ACTUARIAL VALUE - 78.74%

**BENEFITS:** AC indicates Allowable Charges. R&C indicates Reasonable & Customary Charges

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aggregate Maximum Benefit per Policy Year per Covered Person</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible Amount per Policy Year per Covered Person</strong></td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit per Policy Year per Covered Person</strong></td>
<td>$6,350</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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 ("R&C") 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, 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.

## INPATIENT

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Daily Room &amp; Board Maximum</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Limited to the average semi-private rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Miscellaneous Expense</strong>: includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses</td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td><strong>Maternity Benefits</strong></td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td><strong>Pre-Admission Testing</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Confinement must occur within 14 days of the testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>During Hospital Confinement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Expense</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Includes benefit for Assistant Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>In conjunction with surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In-Hospital Doctor's Fees Expense</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Services of a Doctor other than a Doctor who performed surgery on or administered anesthesia to the Covered Person. Limited to one visit per day and not related to Physiotherapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Houston Community College 2016-2017 Student Health Insurance Plan

### Psychiatric Conditions Expense

<table>
<thead>
<tr>
<th>Condition</th>
<th>AC Coverage</th>
<th>R&amp;C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Mental Illness</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Mental and Nervous Disorders</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
</tbody>
</table>

### Alcoholism and Substance Abuse Expense

<table>
<thead>
<tr>
<th>Condition</th>
<th>AC Coverage</th>
<th>R&amp;C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
</tbody>
</table>

### OUTPATIENT

<table>
<thead>
<tr>
<th>Service Description</th>
<th>AC Coverage</th>
<th>R&amp;C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Includes benefit for Assistant Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>In conjunction with surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>When scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Surgical Only</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Other outpatient services performed in a Hospital including, but not limited to: diagnostic x-ray and laboratory services; radiation therapy and chemotherapy; diagnostic services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and laboratory procedures)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery</td>
<td>80% of Ac</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>For use of Hospital emergency room, including operating room, laboratory and x-ray examinations, supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Co-pay Amount of $50 will apply to each visit to the Hospital emergency room unless the Covered Person is admitted to the Hospital as an inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services as mandated by Patient Protection and Affordable Care Act</td>
<td>100% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The applicable Deductible(s), Co-pay Amounts, and coinsurance shall not apply to services rendered by a PPO provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Laboratory and X-Ray Examinations</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>(Not otherwise covered under Preventive Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT Scan/MRI/PET Scan</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment and Orthopedic Appliance</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>No benefits payable for rental charges in excess of the purchase price. Replacement not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic Braces and Appliances</td>
<td>80% of Ac</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Benefits are payable only upon Doctor’s written prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Prosthetic Appliances and Devices</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td><strong>Rehabilitative Services/Habilitative Services</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Physiotherapy, occupational therapy, chiropractic, cardiac/pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech and Hearing and Therapy</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td><strong>Dialysis and Filtration Procedures</strong></td>
<td>80% of AC</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td><strong>Out of Hospital Doctor’s Fees Expense:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor (other than Specialist)</td>
<td>80% of AC after a $15 Co-pay per visit</td>
<td>60% of R&amp;C after a $15 Co-pay per visit</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not to exceed one visit per day (more than one visit per day may be allowed, provided the 2\textsuperscript{nd} and subsequent visits are not with the same Doctor). Benefits do not apply when related to surgery. Includes benefits for outpatient contraceptive services, including consultations, examinations, procedures and medical services directly related to the use of contraceptive methods to prevent unplanned pregnancy under Preventive Services. Includes injections when administered in the Doctor’s office; and infusion therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consultant’s Fee Expense</strong></td>
<td>80% of AC after a $15 Co-pay per visit</td>
<td>60% of R&amp;C after a $15 Co-pay per visit</td>
</tr>
<tr>
<td>When requested and ordered by the attending Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Expense</strong></td>
<td>80% of R&amp;C</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td><strong>Dental Treatment Expense (Injury Only)</strong></td>
<td>80% of AC</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>For treatment of Injury to Sound Natural Teeth. Maximum Amount per tooth $100</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric Dental Treatment Expense</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Covered Persons under age 19 only, subject to an additional Deductible of $250 per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Diagnostic/Preventive Services</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>For Basic Services</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>For Primary Services</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>For Orthodontic Services</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td><strong>Benefits include:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Examination (Preventive), X-Ray and Pathology, Prophylaxis and Fluoride Applications (Preventive), Amalgam Restorations – Primary Teeth, Amalgam Restorations – Permanent Teeth, Synthetic Restorations, Oral Surgery (Includes local anesthetics and routine post-operative care), Extractions, Orthodontic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>For details, see the Policy on file with the Policyholder.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescribed Medicines Expense</strong> - applies to all prescribed FDA-approved birth control methods. The Copay will be waived for prescribed FDA-approved birth control Pharmacy services provided by Cigna Rx. For Cigna Pharmacy locations visit <a href="http://www.cigna.com">www.cigna.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copay per prescription for each 30 day supply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic: $20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulary Brand Name Drug: $40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Formulary Brand Drug: $80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Brand Drug: $20</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Conditions Expense</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe Mental Illness</td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Mental and Nervous Disorders</td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
</tbody>
</table>
### Alcoholism and Substance Abuse Expense

<table>
<thead>
<tr>
<th>Alcoholism and Substance Abuse Expense</th>
<th>Paid the same as any other</th>
<th>Paid the same as any other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sickness</td>
<td>Sickness</td>
</tr>
</tbody>
</table>

### Pediatric Vision Care Expense

For Covered Persons under age 19 only
Covered Percentage: 60% of R&C

<table>
<thead>
<tr>
<th>Maximum Amount:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Plastic Lenses:</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$50</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$50</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$50</td>
</tr>
<tr>
<td>Progressive</td>
<td>$50</td>
</tr>
</tbody>
</table>

| Frames                                  | $100                     |
| Contact Lenses (in lieu of eyeglass lenses and frames) |                          |
| Fit, Follow-up & Materials:             |                          |
| Effective                               | $75                      |
| Medically Necessary                     | $75                      |

### Home Health Care Expense – maximum of 60 visits per Policy Year

80% of AC: 60% of R&C

### Hospice Care Expense

80% of AC: 60% of R&C

### Urgent Care Expense

80% of AC after $15 Co-pay per visit: 60% of R&C after $15 Co-pay per visit

### Skilled Nursing Facility - maximum of 25 days per Policy Year

80% of AC: 60% of R&C

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**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, subject to the Policy limitations, 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 13 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

**MEDICAL EVACUATION**

The Company will pay, subject to the limitations set out herein, 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 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 13 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.
ACCIDENTAL DEATH & DISMEMBERMENT

The Company will pay the benefit below for Injuries to a Covered Person: (a) caused by an Accident which happens while covered by the Plan; and (b) which directly, and from no other cause, result in any of the losses listed below within 365 days of the Accident that caused the Injury.

For Loss Of:                         Maximum Amount
Life .................................................. $5,000
Both Hands or Both Feet.................. $5,000
Sight of Both Eyes............................. $5,000
One Hand and the Sight of One Eye....... $5,000
One Foot and the Sight of One Eye....... $5,000
One Hand or One Foot......................... $2,500
The Sight of One Eye......................... $2,500
Thumb and Index Finger of the Same Hand... $1,250

“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 Student or 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.

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” (“AC”) 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
– cardiac decompensation or missed abortion; or
– similar medical and surgical 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.)

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if the cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the child or mother.

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

“Co-pay” means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

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

“Covered Person” means a Covered Student insured under the Policy.

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

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

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

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

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

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

“Eligible Expense” as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury:
(a) not in excess of the Reasonable and Customary charges; or
(b) not in excess of the charges that would have been made in the absence of this coverage;
(c) with respect to the Preferred Provider, is the Allowable Charge;
(d) is the negotiated rate, if any; and
(e) incurred while the 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 Sickness or Injury for which health care services are provided in a Hospital emergency facility, freestanding emergency medical facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person’s condition, Sickness or Injury, is of such nature that failure to get immediate medical care could result in: (a) placing the Covered Person’s health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of a bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

“Freestanding emergency facility” means a facility, structurally separate and distinct from a Hospital that receives an individual and provides emergency care and is licensed by the state of Texas under Chapter 254 of the Health and Safety Code.

“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
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 licensed or owned by the state of Texas when the Hospital is located in Texas; otherwise it is accredited.

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.

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

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

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

A service or supply will not be considered 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.

"Personal Item" is one which is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

"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 has been reserved before the tests are made; Hospital Confinement begins within 14 days after the tests; and the Covered Person is physically present for the tests. In the event pre-admission testing is ordered by the attending Doctor and the Hospital Confinement and/or surgery are subsequently canceled, benefits for pre-admission testing and services already performed will be covered and benefits will be payable under the Policy based on the available coverage.

“Preventive Services” mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:
1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding 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.

“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.

“Totally Disabled” and “Total Disability” means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a Covered Student from attending classes at the location where he or she is enrolled or if such classes are not in session, from doing the substantial and material activities that are normal for a person in good health of the same age and sex.

EXCLUSIONS AND LIMITATIONS

The Plan does not cover nor provide benefits for loss or expenses incurred:
1. as a result of dental treatment, or dental x-rays except as specifically provided in the Plan. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
2. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
3. 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.
4. for Injury or Sickness resulting from war or act of war, declared or undeclared.
5. as a result of an Injury or Sickness for which the Covered Person is entitled to benefits under any Workers’ Compensation or Occupational Disease Law.
6. 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.
7. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
8. for cosmetic surgery. “Cosmetic surgery” shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. It also shall not include breast reconstructive surgery after a mastectomy.
9. for injuries sustained as the result of a motor vehicle accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.

10. for preventive treatment, testing, immunizations, injections, medicines, sera, vaccines, vitamins, anti-toxins except as specifically provided in the Plan. This exclusion does not apply to Essential Health 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 or complications arising therefrom; voluntary or elective abortions; elective sterilization or its reversal except as specifically provided in the Plan.

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, except this exclusion will not apply to the Covered Person’s choice of a Doctor if the Doctor is licensed to practice medicine by the Texas State Board of Medical Examiners.

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. This exclusion does not apply to Repatriation of Remains coverage or Emergency Evacuation coverage.

17. for or in relation to orthopedic shoes or devices intended to be placed inside shoes or other footwear except pediatric appliances for the prevention of complications associated with diabetes.

18. for surgery and/or treatment of: acupuncture; gynecomastia; breast implants; or breast reduction unless Medically Necessary following a mastectomy; circumcision; weak, strained or flat feet; corns, calluses and bunions; routine care of toenails, except when treatment is necessary due to diabetes, circulatory disorder of the lower extremities, peripheral vascular disease, peripheral neuropathy or chronic arterial or venous insufficiency; deviated nasal septum, including submucous resection and/or other surgical correction thereof except for purulent sinusitis; family planning except as specifically provided; 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; learning disabilities; attention deficit disorder; sexual reassignment surgery and related therapy; vasectomy; and alopecia. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.

19. for routine physical examinations, health examinations or preschool physical examinations. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.

20. by a Covered Person who is a United States Citizen for services performed within the Covered Person’s home country if the Covered Person’s home country provides national health insurance.

21. for sterilization or sterilization reversal, including surgical procedures and devices except as specifically provided; or for birth control except prescription contraceptives drugs and devices.

22. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle and/or off-road four wheeled motorized vehicles); or bungee jumping.

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 of obesity, except resulting from diabetes, regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs; prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complication resulting from weight loss treatments or procedures.

26. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.

27. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

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@aiq.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 Guard®

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 PROCEDURE

When a Covered Person incurs expenses covered by the Policy, he or she may file a claim online or obtain a claim form from www.studentinsurance.com/Apps/Schools/Default.aspx?id=322. Submit all itemized medical bills to the Claims Office listed below.

Notification of Injury or Sickness must be provided to the Claims Office listed below within 30 days after the date of Injury or treatment of Sickness or as soon thereafter as is reasonably possible. Bills must be submitted within 90 days of the date of treatment.

CLAIMS SHOULD BE MAILED TO

Cigna (EDI #62308)
P.O. Box 188061
Chattanooga, TN 37422-8061

INQUIRING ABOUT CLAIMS/BENEFITS:

Consolidated Health Plans (EDI #87843)
2077 Roosevelt Ave.
Springfield, MA 01104
(877) 657-5030


To access the following functions:
- Online Waiver

Review pertinent account information:
- Verification of Insurance
- Download Online ID Card
- Check Claim Status
- Policy Brochure
- PPO Link

IMPORTANT INFORMATION

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 www.AIG.com

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