Marshall University
(“the Policyholder”)
2016-2017 Medical/Pharmacy Student Health Insurance Plan
(“the Plan”)

Administrator Group Number: S218016
Underwriter Reference Number: CAS9151663
Insurance underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY
(“the Company”) Customer

Service Consolidated
Health Plans
Questions 1-877-657-5030
Email: marshall@studentinsurance.com
To waive/enroll: www.studentinsurance.com/schools/wv/marshall
www.studentinsurance.com

Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series to S30749NUFIC-PPO-WV. The Policy on file at the University contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this 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=574 or upon request. The Plan also covers Mandated Benefits as required by the State of West Virginia. Travel Assistance services provided by Travel Guard Group, Inc. (“Travel Guard”). Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.
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ELIGIBILITY
All Medical and Pharmacy students at Marshall University are eligible for coverage and will be automatically enrolled in the Marshall University Student Health Insurance Plan ("the Plan") and the cost for the insurance will be charged to the student’s account unless the student waives coverage under the Plan by showing proof of comparable coverage under another U.S. health insurance plan by the waiver deadline. To waive coverage under the Plan, students must complete the waiver form available at http://studentinsurance.com/Apps/Schools/Default.aspx?ID=574. The waiver deadline is September, 7, 2016 for the Annual coverage term and January 31, 2017 for the Spring/Summer coverage term. The Spring/Summer coverage-only term is available for new students to the University for the Spring/Summer term only.

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 60 days of the date of ineligibility under the other creditable coverage. (Premiums will not be pro-rated.) Proof of ineligibility under the other creditable coverage plan is required at the time of enrollment. If the student experience ineligibility under another creditable coverage, please email proof of ineligibility to qualifier@studentinsurance.com. An eligible student must actively attend classes at the University for at least the first 30 days of the period for which he or she is enrolled. Except in the case of full withdrawal from school due to Sickness or Injury, any student withdrawing from school during the first 30 days of the period for which he or she is enrolled will not be covered under the Plan and a full refund of premium will be made less any claims paid. Students who fully withdraw after such 30 days will remain covered under the Plan and no refund will be made. Distance education courses do not fulfill the eligibility requirements that the student actively attended classes. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company’s only obligation is to refund premium less any claims paid.

Eligible 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 60 days of marriage, birth or adoption. A Covered Student may enroll his or her Dependents by completing the enrollment process at www.studentinsurance.com/schools/wv/marshall by the deadline date (September 7, 2016 for the Annual coverage term or January 31, 2017 for Spring/Summer coverage term (Spring Summer coverage term is only available to Dependents of new students to the University for the Spring/Summer coverage term only). Dependents must be enrolled in the same coverage term in which the Covered Student is enrolled.
TERM OF COVERAGE

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

The coverage of an eligible student, including the student who initially waived coverage and subsequently enrolls within 60 days of ineligibility under another creditable coverage, shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the day after the date for which the first premium for the Covered Student’s coverage is received by the Company; (3) the date the Policyholder’s term of coverage begins; or (4) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the University.

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.

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

(a) the date the Policy terminates;
(b) the last day for which any required premium has been paid; or
(c) the date on which the Covered Student withdraws from the school:
   (1) because of entering the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made within 90 days of leaving school); or
   (2) when the withdrawal from school is during the first 30 days of the period for which the student is enrolled and is for a reason other than full withdrawal from school due to Sickness or Injury (a full refund of premium will be made (less any claims paid) when written request is made within 90 days of leaving school).

If withdrawal from the University is for other than (1) or (2) above, no premium refund will be made. Students, including those who fully withdraw from the University during the first 30 days due to Injury or Sickness, will be provided for the Policy term for which they are enrolled and for which premium has been paid.

Except as specifically provided, insurance for a Covered Student’s Dependent will end when insurance for the Covered Student ends.

EXTENSION OF BENEFITS

If the Covered Person is receiving treatment for a Sickness or Injury on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred for that Sickness or Injury until the earliest of the following: (a) the date the Sickness or Injury ends; (b) the end of the 12 month period following the date of termination of insurance; or (c) the date applicable Maximum Amount is reached.

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.

COORDINATION OF BENEFITS PROVISION

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

2016-2017 STUDENT INSURANCE PLAN COST*

<table>
<thead>
<tr>
<th>Premium</th>
<th>Annual 8/1/16 - 7/31/17</th>
<th>Spring/Summer 1/1/17 - 7/31/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(New Students to the University for the Spring/Summer term Only)</td>
</tr>
<tr>
<td>Student Only</td>
<td>$2,729</td>
<td>$1,593</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,729</td>
<td>$1,593</td>
</tr>
<tr>
<td>Each Child**</td>
<td>$2,729</td>
<td>$1,593</td>
</tr>
</tbody>
</table>

*Plan cost includes 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.
**MARSHALL UNIVERSITY SCHEDULE OF BENEFITS**

This Plan would satisfy the Platinum Level – Actuarial Value 90.06%.

Note: For Injury, the Covered Student must seek treatment and incur the first Eligible Expense within 30 days after the date of the Accident causing the Injury.

<table>
<thead>
<tr>
<th>Maximum Benefit per Policy Year</th>
<th>Health Care at Student Health Services (SHS)</th>
<th>Health Care In-Network PHCS / Multiplan PPO Network</th>
<th>Health Care Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Year Deductible per Covered Person.</td>
<td>None</td>
<td>None</td>
<td>$1,500</td>
</tr>
<tr>
<td>Out-of-Pocket Limit*</td>
<td>None</td>
<td>$1,500 per Covered Person</td>
<td>$6,350 per Covered Person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000 per Family</td>
<td>$12,700 per Family</td>
</tr>
</tbody>
</table>

* The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which the Covered Person is responsible due to Covered Percentages less than 100% reach the Out-of-Pocket Limit. The Out-of-Pocket Limit includes Deductibles, Co-payments and Coinsurance. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary; charges in excess of any specified maximum; or charges incurred for any services not covered under the Policy.

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

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

### INPATIENT

**Pre-Notification Recommended**

<table>
<thead>
<tr>
<th>Health Care at Student Health Services (SHS)</th>
<th>Health Care In-Network PHCS / Multiplan PPO Network</th>
<th>Health Care Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Maximum, limited to the average semi-private rate, except if Intensive Care Unit.</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense (includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital Expenses)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $300 Co-pay per Hospital Admission</td>
</tr>
<tr>
<td>Pre-Admission Testing (Hospital Confinement must occur within 7 days of the testing)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: (a) rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges, limited to $5,000 per Policy Year</td>
</tr>
<tr>
<td>Physiotherapy during Hospital Confinement</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>Service Description</td>
<td>Outpatient Coverage</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Expense</strong></td>
<td>Health Care at Student Health Services</td>
<td>Health Care In-Network PHCS / Multiplan PPO Network</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
<td>75% of Reasonable &amp; Customary</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td><strong>Anesthesia (professional services)</strong></td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>In-Hospital Doctor’s Fees Expense (limited to 1 visit per day and not related to Physiotherapy)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td><strong>Serious Mental Illness &amp; Substance Abuse Expense/Mental and Nervous Disorders Expense</strong></td>
<td>Not Applicable</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Maternity, Complications of Pregnancy and Newborn Care</td>
<td>Not Applicable</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td><strong>Health Care at Student Health Services</strong></td>
<td><strong>Health Care In-Network PHCS / Multiplan PPO Network</strong></td>
</tr>
<tr>
<td><strong>Surgical Expense</strong></td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td><strong>Anesthesia (professional services)</strong></td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous (when scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines).)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Non-Surgical Outpatient services performed in a Hospital including, but not limited to: diagnostic x-ray and laboratory services; diagnostic services and medical procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and laboratory procedures)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery (for use of Hospital Emergency Room, including attending Doctor’s charges, operating room, laboratory and x-ray examinations, supplies) The Co-pay will not apply if the Covered Person is admitted to the Hospital as an inpatient.</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $200 Co-pay per visit</td>
</tr>
<tr>
<td>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 (as specified by the Patient Protection and Affordable Care Act).</td>
<td>100% of Allowable Charges, not subject to Deductible, Co-pay Amounts or Coinsurance</td>
<td>100% of Allowable Charges, not subject to Deductible, Co-pay Amounts or Coinsurance</td>
</tr>
<tr>
<td>Service Description</td>
<td>Benefit Description</td>
<td>Deductible</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>CAT Scan / MRI and/or PET Scan</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Chemotherapy / Radiation Therapy</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment*/Braces and Appliance/Prosthetic Appliances and Devices</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges</td>
</tr>
<tr>
<td>*No benefits will be payable for rental charges in excess of the purchase price.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services and Medical Procedures performed by the Doctor (other than Doctor’s visits, Physiotherapy, x-rays and lab procedures)(not otherwise covered under Preventive Benefits)</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Rehabilitative Services/Habilitative Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy/Physiotherapy</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Cardiac/Pulmonary</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Speech and Hearing Therapy</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Out of Hospital Doctor’s Fees Expense (Doctor (other than Specialist) or Specialist) (Benefits are limited to one visit per day and does not apply when related to surgery. More than one visit per day may be allowed, provided the 2nd and subsequent visits are not with the same Doctor.) Includes injections when administered in the Doctor’s office; and infusion therapy.</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Consultant’s Fees Expense</td>
<td>Not Applicable</td>
<td>80% of Allowable Charges after a $20 Co-pay per visit</td>
</tr>
<tr>
<td>Ambulance Expense</td>
<td>Not Applicable</td>
<td>100% of Allowable Charges</td>
</tr>
<tr>
<td>Dental Treatment Expense (Injury to Sound Natural Teeth Only)</td>
<td>Not Applicable</td>
<td>100% of Allowable Charges</td>
</tr>
<tr>
<td>Benefit</td>
<td>Type</td>
<td>Benefit Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Pediatric Dental Treatment Expense (for Covered Persons under age 19 only) | Not Applicable        | Preventive Services  
Basic Services  
Primary/Major Services  
Orthodontic Services  

Please see the complete Policy on file with the School for full details.                                                                 |
| Dental Treatment Expense for Impacted Wisdom Teeth                     | Not Applicable        | 80% of Allowable Charges after a $20 Co-pay per visit  
75% of Reasonable & Customary after a $20 Co-pay per visit |
| Prescribed Medicines Expense                                            | Not Applicable        | 100% of Reasonable & Customary, subject to the following Co-pay per prescription or refill:  
 Generic: $15  
 Formulary Brand Name: $40  
 Non-Formulary Brand Drug: $75  
 Speciality Brand Drug: 25% of charges with a $100 minimum - $500 maximum Co-pay per prescription or refill |
|                                                                        |                       | For Pharmacy and prescription help please call 1-877-657-5030. To obtain a formulary listing (including prior approval prescription drugs), visit [www.studentinsurance.com/schools/wv/marshall](http://www.studentinsurance.com/schools/wv/marshall) and click on “Pharmacy”. |
| Elective Abortion                                                       | Not Applicable        | Paid the same as any other Sickness  
Paid the same as any other Sickness |
| Serious Mental Illness & Substance Abuse Expense/Mental and Nervous Disorders Expense | Not Applicable        | Paid the same as any other Sickness  
Paid the same as any other Sickness |
| Pediatric Vision Care Expense (for Covered Persons under age 19 only)   | Not Applicable        | 100% of Reasonable & Customary after a $25 Co-pay per visit  
100% of Reasonable & Customary after a $25 Co-pay per visit |
| Examination:                                                            |                       | Maximum Benefit:  
$150  
$150  
$150  
$150  
$150 |
| Materials:                                                              |                       |  
Standard Plastic Lenses  
Single vision  
Bilocal  
Trifocal  
Lenticular  
Progressive  
Frames  
Contact Lenses (in lieu of eyeglass lenses and frames)  
Fit, Follow-up and Materials  
Effective  
Medically Necessary  
Benefits are limited to one examination per Policy Year; one pair of lenses per Policy Year; and one frame per Policy Year. |
|                                                                        | $150  
$150 |
**Please see the complete Policy on file with the School for full details.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care Expense</td>
<td>Not Applicable 80% of Allowable Charges, limited to 100 visits per Policy Year 75% of Reasonable &amp; Customary, limited to 100 visits per Policy Year</td>
</tr>
<tr>
<td>Hospice Care Expense</td>
<td>Not Applicable 80% of Allowable Charges 75% of Reasonable &amp; Customary</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Not Applicable 80% Allowable Charges after a $50 Co-pay per visit 75% Reasonable &amp; Customary after a $50 Co-pay per visit</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Not Applicable 80% of Allowable Charges after a $200 copay per admission 75% of Allowable Charges after a $300 copay per admission</td>
</tr>
<tr>
<td>Infertility Services Expense</td>
<td>Not Applicable Paid the same as any other Sickness Paid the same as any other Sickness</td>
</tr>
</tbody>
</table>

Benefits are payable for the Eligible Expenses incurred by the Covered Student or the Covered Student’s Spouse for infertility services to the same extent as benefits provided for other pregnancy-related procedures. Eligible Expenses include treatment for the correction of a physical or medical problem associated with infertility. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

Eligible Expenses do not include and no benefits are payable for in-vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

**ACCIDENTAL DEATH AND DISEMBLEMENT BENEFIT:**

**Maximum Amount: $5,000**

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

<table>
<thead>
<tr>
<th>Loss of Life/Care</th>
<th>Percentage of Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both Hands or Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>The Sight of One Eye</td>
<td>50%</td>
</tr>
</tbody>
</table>

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

If a Covered Person suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.
REPATRIATION OF REMAINS AND EMERGENCY 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 15 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

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

The Doctor ordering the Emergency Medical Evacuation must certify: (a) that the severity of the Covered Person’s Injury or emergency
Sickness warrants his or her Emergency Medical Evacuation; and (b) the Covered Person has been Hospital Confined for at least five
(5) consecutive days prior to Emergency Medical Evacuation. All Transportation arrangements made for the Emergency 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 Emergency 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 15 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 West Virginia 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=574 or upon request.

PPO PROVIDERS
Persons insured under the Plan may choose to be treated within or outside of the PHCS/MultiPlan PPO Network. This network consists
of Hospitals, Doctors and other health care providers organized into a network for the purpose of delivering quality health care at
affordable rates. Reimbursement rates will vary according to the source of care as described under the Schedule of Benefits. PPO
Providers are also available outside the School’s coverage area. A complete listing of participants is available at
www.studentinsurance.com or by contacting Consolidated Health Plans. To locate a PPO Provider please call 1-877-657-5030 or visit
www.studentinsurance.com/schools/wv/marshall

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

1. as a result of dental treatment, except as provided elsewhere in the Policy. This exclusion does not apply to Preventive Benefits
   mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by the Policyholder’s Health Service, Infirmary or Hospital, or by health care
   providers employed by the Policyholder or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such except as specifically
   provided; radial keratotomy or laser surgery; hearing aids. This exclusion does not apply to Preventive Benefits mandated by the
   Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids or Cochlear implants or other treatment for hearing defects and problems. “Hearing
   defects” means any physical defect of the ear which does or can impair normal hearing apart from the disease process.
5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial
   navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline
6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which the Covered Person is entitled to benefits under any Workers’ Compensation or
   Occupational Disease Law.
8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered
Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.

9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.

10. for cosmetic surgery, except as required to correct an Injury for which benefits are otherwise payable under the Policy or as specifically provided for in the Policy. "Cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect; or as a result of an act of family violence when the person inflicting the injury was convicted of a felony, a lesser included misdemeanor offense, or a charge of domestic battery for inflicting the injury. It also shall not include breast reconstructive surgery after a mastectomy.

11. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.

12. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins anti-toxins except as specifically provided in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

13. 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.

14. for Elective Treatment or elective surgery or complications arising therefrom; elective sterilization or its reversal except as specifically provided in the Policy.

15. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

16. for any services rendered by a Covered Person’s Immediate Family Member.

17. for any treatment, service or supply which is not Medically Necessary.

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

19. for surgery and/or treatment of: acne except prescriptions for treatment of complications; acupuncture or acupressure; biofeedback-type services; weak, strained or flat feet; corns, calluses and bunions; fallen arches, chronic foot strain or symptomatic complaints of the feet; or to improve comfort or appearance of the feet; family planning except as specifically provided; fertility tests; nutrition programs. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

20. by a Covered Person who is not a United States Citizen for services performed within the Covered Person’s home country if the Covered Person’s home country provides national health insurance.

21. for chiropractic care or treatment not related to the treatment of Injury or Sickness.

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; racing or speed contests; hang gliding; parasailing; sky diving; flight in an ultra light aircraft; glider flying; sail planing; parachuting; or any other hazardous sport or hobby.

23. for rest cures or custodial care.

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.

27. for alternative health care, including but not limited to naturopathy, herbal medicine, acupuncture, light therapy.

28. for hypnosis.

29. for Rolfing procedures; reflexology.

30. for hormone treatment or hormone therapy not related to the treatment of a Sickness.

31. for replacement of Durable Medical Equipment.

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.

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

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

“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.)

"Co-insurance" means the percentage of the Eligible Expense payable by the Covered Person under the Policy.

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

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

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

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

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

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

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

The "child" of a Covered Student or Spouse will not be denied enrollment under the Policy because he or she:

(a) was born out of wedlock;
(b) is not claimed as a dependent on the Covered Student’s or Spouse’s federal tax return;
(c) does not reside with the Covered Student or Spouse in the Policy's service area.

The term "child" includes a child of the Covered Student or Spouse who is a non-custodial parent. In such case, the Company will:

(a) provide information to the custodial parent as may be necessary for the child to obtain benefits applicable to Covered Dependents under the Policy;
(b) permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for Eligible Expenses without the approval of the non-custodial parent; and
(c) make payments on claims directly to the custodial parent, health care provider or the social services district furnishing medical assistance to the child, whichever is applicable.

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

"Doctor" as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified 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.

"Elective Treatment" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage.
Elective treatment includes, but is not limited to: breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum; treatment for weight reduction; and learning disabilities.

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

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

"Emergency Medical Condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that a Prudent Layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health or pregnancy of the person afflicted with such condition in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person.

For purposes of this definition, the following terms apply:

"Emergency Medical Services" means those services required to screen for or treat an Emergency Medical Condition until the condition is Stabilized, including pre-Hospital care.

"Prudent Layperson" means a Covered Person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an Emergency Medical Condition exists for which emergency treatment should be sought.

"Stabilize" with respect to an Emergency Medical Condition, means to provide medical treatment of the condition necessary to assure, with reasonable medical probability, that no medical deterioration of the condition is likely to result from or occur during the transfer of the Covered Person from a facility.

"Emergency Services" means, with respect to an Emergency Medical Condition:

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

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

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

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

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
(c) the drug, device, medical care or treatment or the patient’s informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;
(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its
efficacy as compared with standard means of treatment of diagnosis.

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

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

Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; (c) as a place for custodial or educational care; or (d) as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

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

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

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

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

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

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

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

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

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

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

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

“Policy Year” means the period of time measured from the Effective date to the Termination Date.

“Pre-Admission Testing” means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person’s condition in anticipation of a scheduled Hospital Confinement and required prior to surgery; a Hospital bed and operating room have been reserved before the tests are made; Hospital Confinement begins within [3 – 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.

“Pre-Notification” means a method by which insurance companies monitor utilization through prior notification to the plan of services to be rendered.

“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.

“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.

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

PRE-NOTIFICATION RECOMMENDED

Call 1-877-657-5030

The Covered Person should fulfill the Pre-Notification requirement of the Plan.

Pre-Notification of Non-Emergency Hospitalizations: The patient, Doctor or Hospital should telephone 1-877-657-5030 at least 5 days prior to the planned admission.

Notification of Emergency Admissions: The patient, patient’s representative, Doctor or Hospital should telephone 1-877-657-5030 within 2 days of admission.

Consolidated Health Plans is open for Pre-Notification calls from 8:00 a.m. to 5:00 p.m., E.S.T., Monday through Friday.

IMPORTANT: Pre-Notification is not a guarantee that benefits will be paid.
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 within 90 days after the date of such loss.

Claims can be submitted online at http://www.studentinsurance.com/Apps/Schools/Default.aspx?ID=41 or fill in the necessary information and mail all itemized medical and Hospital bills to the following address:

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

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

**TRAVEL GUARD®**

**Description of Travel Assistance Services for Students**

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

**How to contact Travel Guard:**

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

Outside the U.S. and Canada:

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

Email us at assistance@aig.com

**When to contact Travel Guard:**

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

**Helpful information to have available when you call Travel Guard:**

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

**Travel Medical Assistance**

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

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

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

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

Travel Concierge Services

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

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

Travel Assistance Website and Mobile App

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

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

About AIG Travel and Travel 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.
CREDITABLE COVERAGE
The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Policy is terminated. In addition, Certificates of Creditable Coverage shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time. In order to obtain a Certificate of Creditable Coverage; please contact Consolidated Health Plans at 1-877-657-5030.

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

CLAIMS QUESTIONS
Consolidated Health Plans
1-877-657-5030

STUDENT HEALTH INSURANCE
Website: www.studentinsurance.com
Email: marshall@studentinsurance.com

ONLINE SERVICES
Go online at www.studentinsurance.com and search for your Institution
On this secure site you can:

• Waive Coverage
• Print ID Card
• Update your personal information
• Search for Providers and Hospitals
• View a Summary of Benefits
• View questions and answers about your insurance
• View claims information / EOBS

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