Inside you will find:

- Costs of coverage
- Information on the PPO network
- Schedule of benefits
- Exclusions
- Definitions of insurance terms
- Claim filing instructions

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

Policy Number:
CHH0058784

NOTICE REGARDING HEALTH CARE REFORM

Your student health insurance coverage, offered by National Union Fire Insurance Company of Pittsburgh, Pa. may not meet the minimum standards required by the Health Care Reform Law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. The restriction for annual dollar limits for group and individual health insurance coverage is $2 million for policy years beginning on or after September 23, 2012, but before January 1, 2014. The restriction for annual dollar limits for student health insurance coverage is $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of $500,000 on Essential Health Benefits. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under 26 years of age. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance company for more information.

For more information on how Health Care Reform affects the 2013–2014 Student Health Insurance Plan at your school, visit www.4studenthealth.com/woodbury. If you have any questions or concerns about this notice, contact customer service at 1-800-537-1777.
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ID CARD
If you are enrolled in the Plan, download your insurance ID card at www.4studenthealth.com/woodbury. If you go to a Doctor’s office, urgent care center, Hospital, or pharmacy, you will be asked for your ID card. Carry your insurance identification card with you at all times.

NO-COST LANGUAGE ASSISTANCE SERVICES
You can get an interpreter and get documents read to you in your language. For help, call the number listed on your insurance ID card or 1-800-468-4343. For more help, call the CA Department of Insurance at 1-800-927-4357.

NOTICE
Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-CA. 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.

Underwriter Reference No. CAS9495429

The Policy is Non-Renewable One-Year Term Insurance. Similar coverage may be purchased for the following academic year. It is the Covered Student’s responsibility to obtain coverage the following year in order to maintain continuity of coverage. Covered Students who have not received information regarding a subsequent program prior to the Policy’s Termination Date should inquire regarding such coverage with the University or Ascension Benefits & Insurance Solutions.

Insurance and services provided by member companies of American International Group, Inc. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.
IMPORTANT CONTACT INFORMATION AND RESOURCES FOR YOUR 2013–2014 STUDENT HEALTH INSURANCE PLAN (SHIP)

To download a plan summary, FAQ, or ID card or for further information on this plan, visit: www.4studenthealth.com/woodbury

Insurance Company

Policy Number
CHH0058784

Claims Administrator
For questions regarding eligibility, benefits, or claims, contact:
Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
1-800-468-4343
Monday–Friday, 8:00 a.m. to 5:00 p.m. (4:00 p.m. on Fridays) PT

PPO Network
To locate PPO Doctors and facilities, contact:
First Health Network
1-800-226-5116
www.myfirsthealth.com
Available 24/7/365

Prescription Drugs
To locate a network pharmacy and to manage your medications (including refills and home delivery), contact:
Express Scripts, Inc.
1-800-447-9638
www.express-scripts.com
Available 24/7/365

Travel Assistance Services
When you are traveling away from home and you need assistance with things such as transfer of medical records, legal referrals, lost luggage, and information on travel conditions, contact:
Travel Guard
Inside the U.S. and Canada, call 1-800-626-2427, or outside the U.S. and Canada, ask an AT&T operator to place a collect call to Houston, TX, USA at 1-713-267-2525
Available 24/7/365

Nurse Advice Line
For information and advice on health care issues, including how to manage chronic diseases and develop healthful habits, or for translation services, contact:
Optum NurseLine
1-877-856-8163 (PIN 248)
Available 24/7/365

UNIVERSITY HEALTH SERVICES (UHS)
Health Services Office (Burbank campus): 1-818-252-5238
Counseling Center: 1-818-252-5237
Hours: Monday–Thursday, 9:00 a.m. to 4:00 p.m.; Friday, 9:00 a.m. to noon
Please note: The Health Services Office is closed each summer from May 15 to August 15. When not in school or in the case of an Emergency Medical Condition, students should report to the nearest Doctor or Hospital.
San Diego campus students should report to the Administration Office.
ELIGIBILITY

A student who actively attends classes at Woodbury University for at least the first 45 days of the period for which he or she is enrolled is eligible to enroll in the Student Health Insurance Plan ("SHIP" or the "Plan"). Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the Plan eligibility requirements have been and continue to be met. If and whenever the Company discovers that the Plan eligibility requirements have not been or are not being met, its only obligation is to refund the premium less any claims paid.

Mandatory Students

The following students will be automatically enrolled in SHIP and billed for the premium amount under the plan at the beginning of each semester:

1. All traditional undergraduate students; and
2. All students residing in University-operated housing (including graduate students); and
3. All international students on an F-1 or J-1 visa, including those residing off-campus (insurance coverage purchased from companies outside the U.S. does not meet the University’s insurance requirements).

Mandatory students who have other comparable insurance coverage may elect to waive coverage in SHIP. See Waiver Procedure for Mandatory Students for additional information.

Voluntary Students

All nontraditional (evening and weekend program) students taking six (6) or more credit units, and graduate students taking three (3) or more credit units, who are enrolled in a degree-granting program and who attend classes on campus are eligible to enroll in the Plan on a voluntary basis.

Dependents

Covered Students may also enroll their eligible Dependents in the Plan. An eligible Dependent is: 1) the Covered Student’s Spouse residing with the Covered Student; and 2) the Covered Student’s or Spouse’s child until the date such child attains age 26. For all persons who become Dependents while the Covered Student is insured under the Plan, enrollment and full premium payment must be submitted within 31 days of the family status change (proof of date of birth, adoption, or marriage may be requested).

For questions about enrollment, contact Ascension at 1-800-537-1777 (Monday–Friday, 8:00 a.m. to 5:00 p.m. PT).

WAIVER PROCEDURE FOR MANDATORY STUDENTS

Students who wish to waive coverage under this Plan must go to www.4studenthealth.com/woodbury to complete the online application and submit the required paperwork (copy of insurance card, benefit summary, and/or letter of verification) once each academic year, by the Waiver Deadline Date. If the student’s waiver application is approved, it will remain in effect for the remainder of that academic year.

Waiver Deadline Date
September 13, 2013*

*Note: Students newly enrolling in the Spring term must complete a waiver by the Spring Waiver Deadline Date, which is January 31, 2014.

Students who apply to waive coverage must have other comparable insurance coverage in place. Comparable coverage must meet all of the following requirements:

• Maximum Deductible must be $1,000 or less per Plan year.
• Benefits must be paid at 80% or higher for in-network providers and 50% or higher for out-of-network providers.
• Claims must be paid by a U.S.-based company.
• Underwriting company must be owned, operated, and headquartered in the United States and must be in full compliance with applicable federal laws. International students may not waive coverage under this plan with insurance from their home country.
• Insurance must be accepted in Southern California for Doctor’s visits and urgent care.

Students who are covered under a health plan that does not meet the applicable requirements will not be allowed to waive coverage under this Plan.

Please see the Waiver FAQ, available at www.4studenthealth.com/woodbury, for further questions and instructions on waiving coverage. For additional questions regarding the waiver procedure, please contact Ascension at 1-800-537-1777.
ENROLLMENT PROCEDURE

Mandatory Students
All eligible students who have not waived coverage by the Waiver Deadline Date will be automatically enrolled in the Plan and billed for the premium at the beginning of each semester.

A student who initially waived coverage under this Plan but subsequently experiences Involuntary Loss of Coverage may elect to enroll for coverage under this Plan within 31 days of the date of Involuntary Loss of Coverage by contacting the Business Office about his or her interest to enroll in the Plan for the remainder of the current term. Please note that premium payments cannot be prorated. Students must pay the entire premium for the term in which they are electing to enroll.

Students who have waived enrollment in the Plan and later wish to enroll in the school insurance Plan, but who have not had an Involuntary Loss of Coverage, may elect to enroll in the next ensuing term of coverage provided they maintain eligibility status.

Voluntary Students
Eligible students who wish to enroll voluntarily must submit an enrollment form and payment for the full cost of coverage by the Enrollment Deadline Date (please see the Insurance Costs and Dates of Coverage section for deadline dates). Students who enroll voluntarily must purchase the Annual term of coverage, except students graduating January 4, 2014, who may purchase coverage for the Fall term, and new students, who may purchase coverage for the Spring/Summer term or the Summer-only term.

To enroll on a voluntary basis, download a voluntary enrollment form from www.4studenthealth.com/woodbury, then follow the instructions listed on the form and return it with payment to the Business Office.

Dependents
Covered Students who wish to enroll their eligible Dependents must submit an enrollment form and payment for the full cost of coverage by the Enrollment Deadline Date (please see the Insurance Costs and Dates of Coverage section for deadline dates). To enroll dependents, download a dependent enrollment form from www.4studenthealth.com/woodbury, then follow the instructions listed on the form and return it with payment to the Business Office.

Persons who become Dependents while the Covered Student is insured under the Plan are not subject to the Enrollment Deadline Dates. However, enrollment and full premium payment for such Dependents must be submitted within 31 days of family status change (proof of marriage, birth, or adoption may be requested). Otherwise, enrollment cannot be accepted after the Enrollment Deadline Dates (please see the Insurance Costs and Dates of Coverage section for deadline dates).

For questions regarding Dependent or voluntary student enrollment, please contact Ascension at 1-800-537-1777.

TERMS OF COVERAGE

Effective Date
The policy is effective at 12:01 a.m. on August 20, 2013.

Mandatory Students
Coverage for eligible students who do not waive coverage by the Waiver Deadline Date shall become effective at 12:01 a.m. on the on the latest of the following dates: 1) the Plan 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 University’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.

Coverage for an international student will begin at 12:01 a.m. on the date the Covered Person departs his or her home country, or country of regular domicile, if: 1) the Covered Person is traveling directly to the University-sponsored program; and 2) such travel commences within 72 hours of the effective date of coverage for the then-current term for which premium has been paid; and 3) travel is directly from the country of regular domicile to the campus; and 4) such travel is not longer than 48 hours in length.

Voluntary Students
The coverage of an eligible student who enrolls for coverage under this Plan by the Enrollment Deadline Date shall take effect on the latest of the following dates: 1) the Plan Effective Date; 2) the date for which the first premium for the Covered Student’s coverage is received by the Company; 3) the date the University’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.

However, a student who does not enroll himself or herself by the Enrollment Deadline Date may not apply for coverage until the next subsequent semester, unless application for coverage is made within 31 days of Involuntary Loss of Coverage. As a result of Involuntary Loss of Coverage, the student may enroll for coverage for himself or herself. In that case, the insurance for the eligible student becomes effective on the latest of the following dates: 1) the day after the date on which the first premium for the Covered Student’s coverage is received by the Company; 2) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits; or 3) the date the Company gives its written consent.

(continued on page 6)
**Dependents**
Coverage for eligible Dependents becomes effective at 12:01 a.m. on the later of: 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. If enrollment for coverage is made more than 31 days following the date the Dependent becomes eligible, then his or her insurance will become effective only if and when the Company gives its written consent.

**Termination Date**
The policy terminates on August 20, 2014. Insurance for a Covered Student will end at 12:01 a.m. on the first of these to occur:
1. The date the Plan terminates; or
2. The last day for which any required premium is paid; or
3. The date on which the Covered Student withdraws from the school due to:
   a) entering the armed forces of any country;
   b) withdrawal from school during the first 30 days of the period for which enrollment was made; or
   c) departure from the Policyholder’s school for his or her home country.

Dependent coverage will not be effective prior to that the Covered Student or extend beyond that of the Covered Student, except as specifically provided in the Policy.

**INSURANCE COSTS AND DATES OF COVERAGE**

<table>
<thead>
<tr>
<th>Dates of Coverage</th>
<th>Annual</th>
<th>Fall</th>
<th>Spring/Summer</th>
<th>Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/20/13 to 08/20/14</td>
<td>09/20/13</td>
<td>01/04/14</td>
<td>05/13/14</td>
<td>08/20/14</td>
</tr>
<tr>
<td>Waiver Deadline</td>
<td>09/13/13</td>
<td>09/13/13</td>
<td>01/31/14*</td>
<td>N/A</td>
</tr>
<tr>
<td>Enrollment Deadline Date</td>
<td>09/20/13</td>
<td>09/20/13</td>
<td>02/04/14</td>
<td>06/13/14</td>
</tr>
<tr>
<td>for Dependents and Voluntary Students</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>$1,036.00</td>
<td>$ 437.50</td>
<td>$ 608.50</td>
<td>$266.50</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
<td>$2,814.00</td>
<td>$1,172.50</td>
<td>$1,641.50</td>
<td>$703.50</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$1,722.00</td>
<td>$ 717.50</td>
<td>$1,004.50</td>
<td>$430.50</td>
</tr>
</tbody>
</table>

* New students only

The costs of coverage include insurance premium and administrative fees. Please note that voluntary students and Dependents must renew their coverage within 31 days of the termination date of their last term of coverage in order to maintain continuous coverage, regardless of the Enrollment Deadline Date. There is no continuation coverage for this Plan for students and/or Dependents who are no longer eligible.

**Notices of termination and/or renewal of enrollment in the plan are not sent to the Covered Person. It is the Covered Person’s responsibility to renew coverage in a timely manner, subject to continuing eligibility. Eligibility requirements must be met each time premium is paid to continue coverage.**

**REFUND POLICY**
Refund of premium will be made only if the Covered Student withdraws from the University due to:
1. Entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when written request is made within 90 days of leaving school.
2. Withdrawal from the University during the first 45 days of the period for which enrollment was made.
3. Departure from the University for his or her home country. Premiums will be refunded on a pro-rata basis only upon written proof from the University that the Covered Student is no longer an eligible person.

If withdrawal from the University is for other than 1), 2), or 3) above, no premium refund will be made. Students, including those who withdraw from the University during the first 45 days due to Injury or Sickness, will be covered for the Policy term for which they are enrolled and for which premium has been paid.
EXTENSION OF BENEFITS
If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the earliest of: 1) the date the Hospital Confinement ends; 2) the end of the 90 day period following the date his or her coverage terminated; or 3) the date the applicable Maximum Amount is reached.

If 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: 1) the date the Sickness or Injury ends; 2) the end of the 90 day period following the date of termination of insurance; or 3) the date applicable Maximum Amount is reached.

PREFERRED PROVIDER ORGANIZATION
Please read the following information so you will know from whom or what group of providers health care may be obtained.

This Plan has incorporated into the coverage access to the First Health 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 when treated by network providers (PPO). Coverage is available worldwide for Eligible Expenses incurred at 50% of Reasonable and Customary (R&C) charges when treated by non-network providers (non-PPO). However, if such treatment is received in a non-PPO facility due to an Emergency Medical Condition, benefits for Eligible Expenses are payable at the PPO level.

When a Covered Person has incurred $5,000 of out-of-pocket Eligible Expenses for all conditions during a policy year (not including Copays), covered percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person for the remainder of the Policy Year, up to the Maximum Benefit.

For a complete listing of PPO Hospitals and Doctors, call First Health Network at 1-800-226-5116 or visit www.myfirsthealth.com.

It is strongly recommended that Covered Students first contact the Health Services Office before seeing an outside provider.

If a Covered Person is being treated by a PPO Provider for an acute, serious chronic condition, pregnancy, newborn, or a terminal illness and the Provider’s contract terminates with the PPO, the Covered Person may be eligible under certain conditions to continue treatment with the Provider at the PPO rate. Contact the claims administrator, listed on page 3, for details.

All treatment received in a PPO Hospital facility will be paid at the PPO level, whether or not the provider is a PPO provider. However, 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.

Per the Patient Protection and Affordable Care Act, if designation of a primary care physician is required, the Covered Person must be allowed to designate a physician who specializes in pediatrics as the child’s primary care physician if the provider is in the network. No authorization or referral requirement shall apply to obstetrical or gynecological care provided by in-network providers.

UNIVERSITY HEALTH SERVICES (UHS)
Students should first seek outpatient care from the University Health Services Office on the Burbank campus whenever possible. The Health Services Office offers free or low-fee services to all students, regardless of insurance coverage. Some of the free services provided by the Campus Nurse are health assessments, first aid, and a variety of health screenings, including diabetes, cholesterol, body fat analysis, vision, height/weight, and pregnancy tests. Meningitis vaccines are available for a fee. When available, the Campus Nurse can administer flu shots.

The Burbank campus Health Services Office phone number is 1-818-252-5238. For mental health information, call the Burbank campus Counseling Center at 1-818-252-5237. San Diego campus students should report to the Administration Office.

Hours: Monday–Thursday, 9:00 a.m. to 4:00 p.m.; Friday, 9:00 a.m. to noon

Please note: The Health Services Office is closed each summer from May 15 to August 15. When not in school or in the case of an Emergency Medical Condition, students should go to the nearest Doctor or Hospital.

Recommended Doctor for medical services when the University Health Services Office is closed:
Matthew Chan, MD, MPH - Medical Director
Glendale Adventist Occupational Medicine Center
Rapid Care Urgent Care Centers, Burbank/Glendale
600 South Glendale Avenue, Glendale, CA 91205
Phone: 1-818-502-2050
**SCHEDULE OF BENEFITS**

The Company will pay for the Eligible Expenses listed below, up to the following limits.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Benefit:</strong></td>
<td>$500,000 per policy year for all conditions combined</td>
</tr>
<tr>
<td><strong>Deductible:</strong></td>
<td>$50 per policy year</td>
</tr>
<tr>
<td><strong>Office Visit Copay:</strong></td>
<td>$10 PPO / $20 non-PPO per visit</td>
</tr>
<tr>
<td><strong>ER Copay:</strong></td>
<td>$50 per visit (waived only if admitted to Hospital)</td>
</tr>
<tr>
<td><strong>Out-of Pocket Maximum:</strong></td>
<td>$5,000 per policy year</td>
</tr>
</tbody>
</table>

The Covered Person is responsible for paying the Deductible amount listed before the Company will begin paying benefits, except as indicated below. **Eligible Expenses** include the following, subject to the limitations indicated above or below:

### PREVENTIVE/WELLNESS SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO</th>
<th>NON-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Physical Exam</strong></td>
<td>100% of Allowable Charges</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>includes routine well baby, well child, and well woman care, as well as screening for certain conditions such as: cancer, high cholesterol, depression, diabetes, obesity, and sexually transmitted diseases, as recommended by the U.S. Department of Health and Human Services</td>
<td><strong>DEDUCTIBLE &amp; COPAY WAIVED</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>100% of Allowable Charges</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>includes but not limited to: flu shot, tetanus, diphtheria, pertussis, Tdap, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, pneumonia, varicella, meningococcal; only as recommended by the U.S. Centers for Disease Control and Prevention</td>
<td><strong>DEDUCTIBLE &amp; COPAY WAIVED</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptives</strong></td>
<td>100% of Allowable Charges</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>FDA-approved contraceptive methods, as prescribed by a Doctor; contraceptives obtained through a pharmacy must be purchased at an Express Scripts pharmacy</td>
<td><strong>DEDUCTIBLE &amp; COPAY WAIVED</strong></td>
<td></td>
</tr>
</tbody>
</table>

Please visit [www.hhs.gov/healthcare/prevention](http://www.hhs.gov/healthcare/prevention) for more details on what is included under the federal preventive services requirement.

### OUTPATIENT

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO</th>
<th>NON-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor Visits</strong></td>
<td>80% of Allowable Charges after $10 copay per visit</td>
<td>50% of R&amp;C after $20 copay per visit</td>
</tr>
<tr>
<td>limited to one visit per day (does not apply when related to surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Medical Condition Expense</strong></td>
<td>80% of Allowable Charges after $50 copay per visit (waived if admitted to Hospital)</td>
<td>80% of R&amp;C after $50 copay per visit (waived if admitted to Hospital)</td>
</tr>
<tr>
<td>use of emergency room, including operating room, laboratory and x-ray examinations and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Expense</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Anesthetist</strong></td>
<td>80% of Allowable Charges</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>professional services in connection with outpatient surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Day Surgery Miscellaneous</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>when scheduled surgery is performed in a Hospital 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><strong>Physiotherapy</strong></td>
<td>80% of Allowable Charges after $10 copay per visit</td>
<td>50% of R&amp;C after $20 copay per visit</td>
</tr>
<tr>
<td><strong>Chiropractic Treatment; Acupuncture</strong></td>
<td>80% of Allowable Charges after $10 copay per visit</td>
<td>50% of R&amp;C after $20 copay per visit</td>
</tr>
<tr>
<td><strong>Treatment of Mental and Nervous Disorders</strong></td>
<td>80% of Allowable Charges after $10 copay per visit</td>
<td>50% of R&amp;C after $20 copay per visit</td>
</tr>
<tr>
<td><strong>Treatment of Alcoholism or Substance Abuse</strong></td>
<td>80% of Allowable Charges after $10 copay per visit</td>
<td>50% of R&amp;C after $20 copay per visit</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray and Laboratory Services</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Radiation Therapy and Chemotherapy</strong></td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Tests and Procedures</strong></td>
<td>100% of Allowable Charges</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>diagnostic services and medical procedures performed by a Doctor (other than Doctor’s visits, physiotherapy, X-rays, and lab procedures)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued on page 9)
**INPATIENT**

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO</th>
<th>NON-PPO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Confinement/Room and Board and Hospital Miscellaneous</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>daily room and board limited to average semi-private room rate; miscellaneous Hospital expenses, including expenses incurred for anesthesia and operating room; laboratory tests and X-rays (including professional fees); oxygen tent; drugs, medicines (including take-home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses.</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Maternity and Newborn Care</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>while Hospital Confined, and routine nursery care provided immediately after birth, for no less than 48 hours after birth (96 hours for cesarean delivery)</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Nurse Expense</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>private-duty nursing care by a Registered Nurse or Licensed Practical Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Expense</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>professional services in connection with inpatient surgery</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Doctor Visits (other than a Doctor who performed surgery or administered anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of Mental and Nervous Disorders</td>
<td>80% of Allowable Charges for the first 10 days, then 50% for the next 35 days</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>limited to a maximum of 45 continuous days only</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Treatment of Alcoholism or Substance Abuse</td>
<td>80% of Allowable Charges for the first 10 days, then 50% for the next 35 days</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>limited to a maximum of 45 continuous days only</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% of R&amp;C</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment/ Orthopedic Appliances/Prosthetic Appliances and Devices</td>
<td>80% of R&amp;C</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Consultant Doctor Fees</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Dental Treatment</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>for Injury to sound natural teeth only; up to a maximum of $100 per tooth and $500 per policy year</td>
<td>80% of R&amp;C</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Severe Mental Illness and Serious Emotional Disturbances of a Child</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>including complications of pregnancy</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Abortion Expense</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>up to a maximum of $500 per policy year</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Routine Screening for STDs</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Shots and Injections</td>
<td>80% of Allowable Charges</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Medical Evacuation</td>
<td>$50,000</td>
<td></td>
</tr>
<tr>
<td>Repatriation of Remains</td>
<td>$25,000</td>
<td></td>
</tr>
</tbody>
</table>

**OUTPATIENT PRESCRIPTION DRUGS**

<table>
<thead>
<tr>
<th>Service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Express Scripts Pharmacies</td>
<td></td>
</tr>
<tr>
<td>covered at 100% after Copay; Copay applies to each 30-day supply; the Deductible is waived; prescription contraceptives are covered (Copays waived); includes medication for the management and treatment of diabetes</td>
<td>Generic: $10 Copay Preferred Brand Name: $20 Copay Non-Preferred Brand Name: $40 Copay For locations call 1-800-447-9638 or visit <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td>Other Pharmacies</td>
<td></td>
</tr>
<tr>
<td>the Covered Person must pay in full at the time it is filled, then submit a claim for reimbursement for the amount the Company is required to pay</td>
<td>50% of R&amp;C</td>
</tr>
</tbody>
</table>

* When treatment or care is received at a PPO Hospital, and, when confined, covered services are rendered by a Doctor or other health care professional not in the PPO network, benefits for Eligible Expenses are payable at the PPO level.
STATE MANDATED BENEFITS
The State of California mandates coverage for the following: 1) equipment, supplies, and outpatient self-management training for diabetes; 2) phenylketonuria (PKU), including enteral formulas and special food products that are part of a diet prescribed by a Doctor; 3) treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child; 4) anesthesia and facility charges for dental procedures under certain circumstances; 5) preventive care for children age 16 and under according to the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; 6) behavioral health treatment for pervasive developmental disorder or autism; 7) mammograms; 8) prostate, colorectal, and cervical cancer screening and generally medically accepted cancer screening tests; 9) breast cancer screening, diagnosis, and treatment; 10) a second medical opinion requested by a Covered Person or Doctor; 11) participation in the Expanded Alpha Fetoprotein (AFP) Program; 12) prosthetic devices to restore a method of speaking incidental to laryngectomy; 13) diagnosis, treatment, and management of osteoporosis; 14) clinical trials for cancer; 15) HIV testing; 16) AIDS vaccine; 17) reconstructive surgery under certain circumstances; 18) telemedicine medical services; 19) prescription contraceptive drugs or devices (if there is a prescription drug benefit); 20) treatment of conditions relating to diethylstilbestrol exposure; 21) Medically Necessary surgical treatment for jawbone conditions (TMJ); 22) screening for blood lead levels in children; 23) maternity services as provided by CA Insurance Code section 10123.87 (a); and 24) any other applicable mandated benefits. Please see the Policy on file with the University for further details.

ACCIDENTAL DEATH AND DISMEMBERMENT
When, as a result of an Injury, the Covered Person sustains a loss as shown below while coverage under the Plan is effective and within 365 days of such Injury, the Company will pay the applicable benefit for the loss.

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

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

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

The exclusions below are in addition to the General Exclusions. No benefits will be payable for any Loss caused by:
1. Sickness, disease, mental incapacity, or bodily infirmity whether the loss results directly or indirectly from any of these;
2. Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning, or an accidental cut or wound independent and in the absence of an underlying Sickness, disease, or condition;
3. Medical or surgical treatment, except for a Loss that results directly from a surgical operation made necessary by an Injury which is the result of an Accident and is performed within three (3) months of the Accident; or
4. Covered Person being intoxicated or under the influence of any controlled substance unless administered on the advice of a Doctor.

In addition to the above, this provision is subject to the General Exclusions as provided.

EMERGENCY MEDICAL EVACUATION
The Company will pay, subject to the limitations set out in the Policy on file with the Policyholder, 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 but not exceeding a $50,000 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. An emergency medical evacuation must be ordered by a Doctor. 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. (See page 17 for details on how to contact Travel Guard.)
**REPATRIATION OF REMAINS**

If a Covered Person suffers loss of life due to Injury or emergency Sickness the Company will pay, subject to the limitations set out in the Policy on file with the Policyholder, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding a $25,000 Maximum Amount per Covered Person. 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. *(See page 17 for details on how to contact Travel Guard.)*

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.

**GENERAL EXCLUSIONS**

The Plan does not cover or provide benefits for loss or expenses incurred:

1. As a result of dental treatment, except for treatment resulting from Injury to natural teeth. This exclusion does not apply to Preventive Services 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, or prescriptions for such except for aphakic patients (including lenses required after cataract surgery and soft lenses or sclera shells to treat Sickness or Injury); radial keratotomy or laser surgery; hearing aids; or prescriptions or examinations for such, except as required for repair caused by a covered Injury; or treatment for visual defects and problems. “Visual defects” means any physical defect of the eye which does or can impair normal vision apart from the disease process. Eye refraction is not covered. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act;
4. As a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;
5. For Injury or Sickness resulting from war or act of war, declared or undeclared;
6. As a result of an Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law;
7. As a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days;
8. For treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
9. For cosmetic surgery except as required to correct an Injury which requires medical treatment within 24 hours of the accident. Cosmetic surgery shall not include reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: a) improve function; or b) create a normal appearance, to the extent possible; or c) as specifically provided for in the Plan. It also shall not include breast reconstructive surgery after a mastectomy;
10. 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;
11. As a result of committing or attempting to commit a felony, or participation in a riot or civil commotion;
12. For Elective Treatment or elective surgery, unless otherwise provided in the Policy;
13. After the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision;
14. For any services rendered by a Covered Person’s Immediate Family Member;
15. For a 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 self-inflicted Injury;
17. For surgery and/or treatment of: acne; allergy, including allergy testing and anti-toxins; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; corns, calluses, and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof; family planning; infertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; nonmalignant warts, moles, and lesions unless Medically Necessary; obesity; premarital examinations; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathy and mandibular retragnathia; sleep disorders, including testing thereof; smoking cessation; vasectomy; and weight reduction. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act;
18. 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); bungee jumping;

(continued on page 12)
19. For Injury resulting from the practicing for, or participating in, interscholastic, intercollegiate, club, professional, and semi-professional sports activity, including travel to and from the activity and practice; racing or speed contests; skin diving; scuba diving; hang gliding; parasailing; sky diving; flight in an ultra light aircraft; glider flying; sail planing; parachuting; mountaineering (where ropes or guides are customarily used); snorkeling; bobsledding; or any other hazardous sport or hobby;

20. For Injury resulting from fighting, except in self-defense;

21. For eye surgery when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring); or

22. For treatment, services, drugs, devices, procedures, or supplies that are Experimental or Investigational.

**PRE-EXISTING CONDITION LIMITATION**

Expenses incurred by a Covered Person as a result of a Pre-Existing Condition will not be considered Eligible Expenses for a period of six (6) months while covered under the Plan.

This limitation will not apply if, during the period immediately preceding the Covered Person’s effective date of coverage under the Plan, the Covered Person was covered under prior Creditable Coverage for six (6) consecutive months. Prior Creditable Coverage of less than six (6) months will be credited toward satisfying the Pre-Existing Condition limitation. This waiver of the Pre-Existing Condition limitation will apply only if the Covered Person becomes eligible and enrolls for coverage within 63 days of termination of his or her prior coverage.

Pre-Existing Conditions do not apply to:

1. A newborn Dependent child; or
2. A child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under the Plan, and the child has not attained 18 years of age;
3. A Covered Person under the age of 19; or
4. Pregnancy or complications of pregnancy.

**Specific Disease Waiver**
The Pre-existing Condition limitation will not apply to the following conditions: malaria; dysentery; tuberculosis; cholera; shigellosis; typhoid fever; typhus; diphtheria; yellow fever; schistosomiasis; and mosquito-borne viral encephalitis. These conditions will be considered a covered Sickness under the Plan even though treatment, diagnosis, or advice was given prior to the Covered Person’s effective date of coverage under the Plan.

**Credit for Prior Coverage**
A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person’s effective date under the Plan will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

**Creditable Coverage** means coverage under any of the following:

1. Any individual or group policy, contract, or program that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for on-site medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers’ compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
2. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395a through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;
3. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;
4. Chapter 55 of Title 10, United States Code;
5. A medical care program of the Indian Health Service or of a tribal organization;
6. A health plan offered under chapter 89 of Title 5, United States Code;
7. A public health plan*;
8. A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

*A public health plan is defined as any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverages to individuals who are enrolled in the plan.
EXCESS COVERAGE

This Plan of insurance is secondary and provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any other valid and collectible insurance. If the Covered Person is insured by other valid and collectible insurance, all benefits payable by such insurance will be determined before benefits will be paid by this Plan. This Plan is the second payor to any other insurance having primary status or no coordination or non-duplication of benefits provision.

If the Covered Person is insured under a group or blanket insurance which is also excess to other coverage, the Plan pays a maximum of 50% of the benefits otherwise payable.

Benefits paid by this Plan will not exceed: 1) any applicable Plan maximums; and 2) 100% of the compensable expenses incurred when combined with benefits paid by any other valid and collectible insurance.

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the brochure.

Accident means an occurrence which: 1) is unforeseen; 2) is not due to or contributed to by Sickness or disease of any kind; and 3) causes Injury.

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

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

Company means the National Union Fire Insurance Company of Pittsburgh, Pa.

Copay means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

Covered Person means a Covered Student and his or her Dependent(s) insured under this Plan.

Dependent means: 1) the Covered Student’s Spouse residing with the Covered Student; or 2) the Covered Student’s or Spouse’s child until the date such child attains age 26.

Doctor means: 1) a legally qualified physician licensed by the state in which he or she practices; and 2) 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 3) 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.

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: tubal ligation; vasectomy; breast reduction, unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; Botox injections; treatment of infertility; and routine physical examinations.

Eligible Expense as used herein means a charge for any treatment, service, or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: 1) not in excess of the Reasonable and Customary charges; or 2) not in excess of the charges that would have been made in the absence of this coverage; 3) is the negotiated rate, if any; and 4) 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 Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following: 1) the Covered Person’s life could be in serious jeopardy; or 2) bodily functions would be seriously impaired; or 3) a body organ or part would be seriously damaged; or 4) serious disfigurement; or 5) serious jeopardy to the health of the fetus; or 6) a condition described in clause (1), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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.

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

1. 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

2. 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)).

(continued on page 14)
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: 1) 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; 2) 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; 3) 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; 4) 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 5) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care, or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis. Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care, or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care, or treatment at the time the expense is incurred.

**Hospital** means a facility which meets all of these tests:

1. It provides inpatient services for the care and treatment of injured and sick people; and
2. It provides room and board services and nursing services 24 hours a day; and
3. It has established facilities for diagnosis and major surgery; and
4. It is supervised by a Doctor; and
5. It is run as a Hospital under the laws of the jurisdiction in which it is located; and
6. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

The term “Hospital” includes: 1) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; 2) an ambulatory surgical center or ambulatory medical center; 3) a mental health hospital if supervised and licensed by the Department of Mental Health; and 4) 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” does not include a place run mainly: 1) as a convalescent home; 2) as a nursing or rest home; or 3) as a place for custodial or educational care.

**Hospital Confinement** or **Hospital Confinement** means a stay of at least 18 consecutive hours 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: 1) Spouse; 2) brother-in-law; 3) sister-in-law; 4) son-in-law; 5) daughter-in-law; 6) mother-in-law; 7) father-in-law; 8) parent (includes stepparent); 9) brother or sister (includes stepbrother or stepsister); or 10) child (includes legally adopted or stepchild).

**Injury** means bodily injury due to an Accident which: 1) results solely, directly, and independently of disease, bodily infirmity, or any other causes; 2) occurs after the Covered Person’s effective date of coverage; and 3) 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.

**Involuntary Loss of Coverage** means that prior coverage has been involuntarily terminated due to no fault of the covered student, which includes a change in eligibility status for coverage as a dependent due to reaching a stated age limit, or coverage that terminates due to a loss of employment by the student or the student’s Spouse or parent. This definition does not include

(continued on page 15)
DEFINITIONS (continued)

coverage that has a predetermined termination date, or expiration of COBRA eligibility, and does not apply to coverage that has been voluntarily terminated.

**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:

1. It is provided only as a convenience to the Covered Person or provider; or
2. It is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
3. It exceeds (in scope, duration, or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. It is Experimental/Investigational or for research purposes; or
5. Could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or
6. 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
7. Involves a service, supply, or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
8. 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.

**Mental and Nervous Disorder(s)** means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder (other than those conditions deemed Severe Mental Illness) on the date the medical care or treatment is rendered to a Covered Person.

**Policyholder** means Woodbury University.

**Pre-Existing Condition** means a Sickness or Injury for which medical care, treatment, diagnosis, or advice, including use of prescription drugs, was received or recommended within the six (6) months prior to the Covered Person’s effective date of coverage under the Plan.

**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: 1) the actual charge; 2) the charge usually made for a covered service by the provider who furnishes it; 3) the negotiated rate, if any; and 4) 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.

**Registered Domestic Partner** means a person who is a party to and files a Declaration of Domestic Partnership with the Secretary of State of California establishing a domestic partnership with another person, subject to the following requirements:

1. Neither person is married to someone else;
2. Neither person is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;

(continued on page 16)
DEFINITIONS (continued)

3. Neither person is related to the other person in the partnership by blood in a way that would prevent them from being married to each other in California;

4. Both persons are at least 18 years of age, unless a court order granting permission and written consent of the parents or guardian of the person under age 18 is filed with the Declaration of Domestic Partnership;

5. Both persons are the same sex, or if opposite sex, at least one person is over 62 years of age;

6. Both persons are capable of consenting to the domestic partnership.

Severe Mental Illness means 1) schizophrenia; 2) schizoaffective disorder; 3) bipolar disorder (manic-depressive illness); 4) major depressive disorders; 5) panic disorder; 6) obsessive-compulsive disorder; 7) pervasive developmental disorder or autism; 8) anorexia nervosa; 9) bulimia nervosa; and 10) Serious Emotional Disturbances of a Child.

Serious Emotional Disturbances of a Child means a Dependent child under age 18 who 1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms; and 2) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

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

Spouse the person to whom the Covered Student is married. The term “Spouse” wherever used in this brochure shall also mean the Covered Student’s Registered Domestic Partner.

CLAIM PROCEDURE

1. In the event of an Injury or Sickness, Burbank campus students should report to the University Health Services Office. San Diego campus students should report to the Administration Office. When not in school, or in the case of an Emergency Medical Condition, Covered Students should report to the nearest Doctor or Hospital.

2. A Covered Person may choose any Doctor or Hospital, but using the Doctors and Hospitals available through the First Health Network (PPO) may decrease costs. For a complete listing of these PPO Hospital and Doctor facilities, call 1-800-226-5116 or visit www.myfirsthealth.com.

3. After treatment, complete the insurance company claim form.
   a) Claim forms are available from www.4studenthealth.com/woodbury.
   b) Include the policy number (as shown on the Covered Student’s ID card) on the claim form.
   c) Answer all the questions and be sure to sign the claim form before submitting it.

4. If there are any other expenses associated with your treatment, such as medicines, X-rays, or laboratory charges, attach these bills to the claim form.

5. Send the claim form and related bills to Personal Insurance Administrators, Inc., at the address below. Try to have all itemized bills attached to the same claim form.
   a) Please do not send bills without the completed claim form. Bills cannot be considered unless all the information required on the claim form is submitted.
   b) A properly completed claim form must be submitted for each Injury or Sickness.

6. All claim forms and bills should be sent to:
   Personal Insurance Administrators, Inc.
   P.O. Box 6040
   Agoura Hills, CA 91376-6040
   Providers may submit claims electronically: PAYER ID 95397

7. For questions regarding claim status once a claim has been submitted, please call Personal Insurance Administrators, Inc., at 1-800-468-4343.

All Hospital and medical bills must be submitted for payment within 90 days after the first date of treatment. Failure to furnish this information within the 90-day period shall not invalidate nor reduce the Covered Person’s claim if it was not reasonably possible to file the claim within this time, provided that the claim is submitted as soon as is reasonably possible. In no event, except in the absence of legal capacity, will a claim be honored later than one (1) year from the date of last medical treatment. Covered Persons have the right to request an independent medical review if benefits have been denied, modified, or delayed based on the Company’s determination that health care services are not Medically Necessary. The Company will provide the Covered Person with a one-page application form and an addressed envelope, which the Covered Person may return to the California Department of Insurance to initiate an independent medical review.

Always keep a copy of all documents submitted for claims.

Covered Students may seek assistance with claims at the Health Services Office on the Burbank campus.
TRAVEL ASSISTANCE SERVICES
The following assistance services are a benefit of your Student Health Insurance Plan.

Description of Services

Information/General:
These services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency exchange rates, local Bank/Government holidays, and, by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage, relay, and translation services.

- Visa and Immunization
- Weather and Exchange Rates
- Environmental and Political Warnings

Technical:
These services provide assistance to members in the event of lost or stolen luggage, personal effects, documents, and tickets. Travel Guard can arrange cash transfers and vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter en-route emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage and Personal Effects Assistance
- Lost Document Assistance and Cash Transfer Assistance
- En-route Travel Assistance
- Claims-related Assistance
- Telephone Interpretation

Medical:
These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard’s Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler’s behalf. These services include Doctor/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

Medical assistance includes:

- Medical Referral
- Outpatient Assistance
- Inpatient Assistance

Medical Transport:

- Evacuation and Repatriation
- Repatriation of Remains

How to Access Travel Guard

How to Contact the 24-hour Assistance Call Center:
Inside the U.S. and Canada, dial 1-800-626-2427 toll-free.
Outside the U.S. and Canada:

- Request an international operator.
- Ask the international operator to connect to an AT&T operator.
- Request the AT&T operator to place a collect call to Houston, TX, USA at 1-713-267-2525.
- Our fax number is 1-262-364-2203.

When to Contact Travel Guard:

- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is a question.

Travel Guard is available 24 hours a day, 7 days a week, 365 days a year.
TRAVEL ASSISTANCE PROGRAM (continued)

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

Information you will need to provide to Travel Guard when you call:
- Advise Travel Guard who you are insured by.
- Provide your Policy number. (CAS9495429)
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

OPTUM NURSELINE
The following is a description of the Optum NurseLine program that is included in the cost of the plan for both students and dependents. This information has been included in this brochure for the convenience of the student and in no way affects the coverage provided by the Student Health Insurance Plan described herein. Optum NurseLine is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.

SHIP provides access to the Optum NurseLine, which provides direct access to nurses who can provide the Covered Person with immediate general information and advice about health care issues. Optum’s skilled nurses deliver satisfaction and peace of mind for nearly any health concern 24 hours a day, seven days a week. For example, NurseLine nurses help callers:
- Learn self-care for minor illnesses and injuries
- Understand diagnosed conditions
- Manage chronic diseases
- Discover and evaluate possible benefits and risks of various treatment options
- Learn about specific medications
- Prepare questions for doctor visits
- Develop and maintain healthful living habits

Bilingual nurses are available to address the needs of Spanish-speaking callers, and through the Language Line translation service they can support callers in more than 140 languages.

Individuals also have access to more than 1,700 recorded messages through the audio Health Information Library.

To access the Optum NurseLine:
1. Call 1-877-856-8163
2. Press 1 for a NurseLine registered nurse
3. Press 2 for the Health Information Library (use the PIN 389)

For further information, visit www.healthforums.com.
CERTIFICATE OF CREDITABLE COVERAGE
Covered Persons no longer eligible to be insured under the Plan who need to obtain proof of insurance may request a Certificate of Creditable Coverage from the Plan administrator (Ascension Benefits & Insurance Solutions). This request can be made by phone or in writing, and it must include the name of the school and the name of each person who is no longer eligible to be insured under the Plan.

AUTHORIZED REPRESENTATION
In accordance with state and federal rules and regulations, we will not disclose individual information without authorization. This includes disclosures to family members for insured individuals who have reached the age of majority. If you would like to authorize an additional party to act as a personal representative for matters pertaining to this insurance Plan, we must have an Authorization Form on file. To request a form, please contact Ascension at the address below or download a form at www.4studenthealth.com/Documents/Privacy/PrivacyAuthorizationForm.pdf and mail it to the address below.

SUMMARY OF PRIVACY POLICY
If you are covered under one of our insurance plans, we are committed to protecting your privacy. We strongly believe in maintaining the confidentiality of the personal information we obtain and/or receive about you. We do not disclose any nonpublic information about you to anyone, except as permitted or required by law. We do not sell or otherwise disclose your personal information to anyone for purposes unrelated to our products and services. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to protect information about you from unauthorized disclosure. We may disclose any information we believe necessary to conduct our business as is legally required. You have the right to access, review, and correct all personal information collected. You may review this Privacy Policy in its entirety, or the Privacy Policies of other entities servicing the Policy, by writing to the address or visiting the website below. You may also submit a request to review your information, in writing, to the address below.

Attention: Privacy Manager
Ascension Benefits & Insurance Solutions
P.O. Box 240042
Los Angeles, CA 90024
Phone: 1-800-537-1777
Facsimile: 1-310-394-0142
Website: www.4studenthealth.com
CA License No. 0G55426

AIG PRIVACY STATEMENT
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 our website at www.studentinsurance.com and click on the Privacy Policy link at the bottom of the page.

To download a plan summary, FAQ, or ID card or for further information on this plan, visit:
www.4studenthealth.com/woodbury