Underwritten by:
National Guardian Life Insurance Company

ahp | Academic HealthPlans℠

Student Health Insurance Plan 2018-2019

Policy Number: 2018A4A18

The 2018-2019 Student Health Insurance Plan is underwritten by National Guardian Life Insurance Company, NBH-280 (2018)PPO IL.
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Please Note: We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your Policy. Please review the meaning of the capitalized terms in the Definitions section.

Eligibility

SAIC requires health insurance coverage for all domestic undergraduate, graduate, exchange and certificate students enrolled full-time, and all international students.

Unless full-time undergraduate, domestic, graduate, exchange and certificate students, and internationals students submit a waiver online through ***saic.myahpcare.com***, they will automatically be enrolled in SAIC's Student Health Insurance Plans. The premium will be charged per semester, to each student's account.

If a student has comparable coverage and wishes to waive SAIC's Student Health Insurance Plan for the entire academic year, a waiver must be completed online by visiting ***saic.myahpcare.com*** by the first day of fall classes. Spring-only waivers are due by the first day of spring classes. Summer waivers are required only of new students who begin their degree plan in the summer.

A student must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless they withdraw from classes due to an Injury or Sickness and the absence is an approved medical leave. Home study, correspondence, Internet classes and television (TV) courses do not fulfill the eligibility requirements that the student must actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students who enroll may also insure their Dependents. Dependent enrollment must take place at the time of student enrollment (or within 30 days if tuition billed), with the exception of newborn or adopted children or a Qualifying Event. **Dependent** means An Insured Student's lawful spouse or lawful domestic partner or civil union partner. A domestic partnership or civil union partnership may be between a same sex or different sex couple. The partnership is subject to all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples; An Insured Student's dependent biological or adopted child or stepchild under age 26; and An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is: a. primarily dependent upon the Insured Student for support and maintenance; and b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap. Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when a Insured Student enrolls a new disabled child under the plan.

Newly Born Children A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. To continue coverage beyond this initial 31-day period, the Insured Person must: 1. Notify Us of the birth; and 2. Pay any additional premium.

Qualifying Event: Eligible students who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event, students should send a copy of the Certificate of Creditable Coverage, the completed Qualifying Events Form and the letter of ineligibility to Academic HealthPlans. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment or legal separation. The premium will be the same as it would have been at the beginning of the semester. However, the effective date will be the later of the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. You may download a form from ***saic.myahpcare.com***.

You are entitled to the benefits described in this brochure, if you have enrolled for this insurance and paid the premium.

Effective and Termination Dates

The Policy on file at the school becomes effective at 12:01 a.m. standard time at the University's address on the later of the following dates:

- The Policy effective date is 08/19/2018; or
- The beginning date of the term for which premium has been paid.

Effective and Termination Dates and Cost			
Domestic and International Students	**From**	**To**	**Cost**
Fall	08/19/18	01/24/19*	$1,050
Spring (New Students)	01/16/19	08/19/19*	$1,050
Spring	01/24/19	08/19/19*	$1,050
Summer (New Students)	06/16/19	08/19/19*	$379

Open Enrollment Periods

The open enrollment periods during which students may apply for, or change, coverage for themselves, and/or their eligible spouses and/or dependents, is as follows:

Domestic Students and Dependents	From	Through
Fall	06/15/18	08/29/18
Spring	11/20/18	01/24/19
Summer	05/01/19	07/08/19

*The coverage provided with respect to the Covered Person shall terminate *08/19/2019* at 12:01a.m. standard time on the earliest of the following dates:

- The date the Policy terminates for all insured persons; or
- The end of the period of coverage for which premium has been paid; or
- The date an Insured Person ceases to be eligible for the insurance; or
- The date an Insured Person enters military service.

You must meet the eligibility requirements listed herein each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage. **Refunds of premium are allowed only upon entry into the Armed Forces, and the Company receives proof of active duty. Otherwise all premiums received by the Company will be considered fully earned and nonrefundable. Such persons will not be covered under the Policy as of the date of their entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.**

The Policy issued to the University is a Non-Renewable, One-Year Term Policy. However, if you still maintain the required eligibility you may purchase the plan the next year. It is the Covered Person's responsibility to enroll for coverage each year in order to maintain continuity of coverage. If you no longer meet the eligibility requirements contact Academic HealthPlans at 1-855-844-3023 prior to your termination date.

Coverage Period Notice

Coverage Periods are established by the University and subject to change from one policy year to the next. In the event that a coverage period overlaps, the prior coverage period will terminate as of the effective date of the new coverage period. In no case will an eligible member be covered under two coverage periods within the same group.

Extension of Benefits

The coverage provided under the plan ceases on the termination date. However, if a Covered Person is Hospital Confined on the termination date for a covered Injury or Sickness for which benefits were paid before the termination date, the Covered Expenses for such covered Injury or Sickness will continue to be paid provided the condition continues, but not to exceed 90 days after the termination date.

The total payments made in respect of the Covered Person for such condition both before and after the termination date will never exceed the maximum benefit for the condition. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Coordination of Benefits

Under a Coordination of Benefits (COB) provision, the plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the Covered Expenses. When one plan does not have a COB provision, that plan is always considered Primary, and always pays first. You may still be responsible for applicable Deductible amounts, Copayments and Coinsurance.

Pre-Certification Process

You must adhere to the Pre-certification process. Failure to comply with the Pre-certification requirements may result in a Pre-certification penalty. You are responsible for notifying the claims administrator at the phone number found on your ID card to begin the Pre-certification process. For inpatient benefits or surgery, the call must be made at leave 5 working days before Hospital Confinement or surgery.

The following inpatient benefits require Pre-certification:

1. All inpatient admissions to a Hospital, Skilled Nursing Facility, facility established primarily for the Treatment of Substance Use Disorder, or residential Treatment facility. The expected length of stay should be included in the notification.
2. All inpatient maternity care after the initial 48/96 hours.

Pre-certification is not required for Medical Emergency or Urgent Care; Hospital Confinement for maternity care; or Obstetric or gynecological care when provided by a Network Provider; or Outpatient treatment

Pre-certification does not guarantee that Benefits will be paid. Your Physician will be notified of Our decision.

Failure by the claims administrator to make a determination within the time periods stated in the policy will be deemed an Adverse Determination subject to an appeal.

The Insured Person should contact his or her Physician with question about any Precertification status.

Schedule of Medical Expense Benefits *(Injury and Sickness)*

***Preventive Services: Network Provider:** The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of Usual and Reasonable Charge when services are provided through a Network Provider. **Non-Network:** The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 60% of the Usual and Reasonable Charge.

The following services shall be covered without regard to any Deductible or Coinsurance requirement that would otherwise apply:

- 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.
- 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 Insured Person involved.
- With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

*Please visit healthcare.gov/preventive-care-benefits/ for more information.

Maximum Benefit *(per Insured Person, per Policy Year)*	**Unlimited**	
Deductible *(per Insured Person, per Policy Year)*	**Network Provider: $ 250** **Non-Network Provider: $ 500**	
Individual Out-of-Pocket Expense Limit* *(per Insured Person, per Policy Year)*	**$ 6,850**	
Family Out-of-Pocket Expense Limit* *(per Family, per Policy Year)*	**$13,700**	
	Network Provider	**Non-Network Provider**
Coinsurance	**80%** **of PPO Allowance for Covered Medical Expenses otherwise stated below**	**60%** **of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below**

**The Out-of-Pocket Expense Limit provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. If the Insured Person uses a Network Provider, any Coinsurance, Deductible, or Copayment will be included in the Network Out-of-Pocket Expense Limit. If the Insured Person uses a Non-Network Provider, any Coinsurance, Deductible, or Copayment will be included in the Non-Network Out-of-Pocket Expense Limit.*

Benefit Payment for Network Providers and Non-Network Providers: The policy provides benefits based on the type of health care provider selected. The Policy provides access to both Network and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers.

Preferred Provider Organization: To locate a Network Provider in your area, consult your Cigna Provider Directory; visit the network website at ***saic.myahpcare.com.***

AT PHARMACIES CONTRACTING WITH THE HEALTHSMART RX®: You must go to a pharmacy contracting with the HealthSmart RX® in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy online at ***saic.myahpcare.com*.**

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

Inpatient Benefits	Network Provider	Non-Network Provider
Hospital Room & Board Expenses Pre-certification required	80% of PPO Allowance	60% of Usual and Reasonable Charge
Hospital Intensive Care Unit Expense, in lieu of normal Hospital Room & Board Expenses Pre-certification required	80% of PPO Allowance	60% of Usual and Reasonable Charge
Hospital Miscellaneous Expenses, for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	80% of PPO Allowance	60% of Usual and Reasonable Charge
Preadmission Testing	80% of PPO Allowance	60% of Usual and Reasonable Charge
Physician's Visits while confined	80% of PPO Allowance	60% of Usual and Reasonable Charge
Inpatient Surgery: Pre-certification required **Surgeon Services** **Anesthetist** **Assistant Surgeon**	80% of PPO Allowance	60% of Usual and Reasonable Charge
Registered Nurse Services, for private duty nursing while confined	80% of PPO Allowance	60% of Usual and Reasonable Charge
Skilled Nursing Facility Expense Benefit Pre-certification required	80% of PPO Allowance	60% of Usual and Reasonable Charge
Mental Health Disorder Benefit Pre-certification required	80% of PPO Allowance	60% of Usual and Reasonable Charge
Substance Use Disorder Benefit Pre-certification required	80% of PPO Allowance	60% of Usual and Reasonable Charge
Outpatient Benefits	**Network Provider**	**Non-Network Provider**
Outpatient Surgery: **Surgeon Services** **Anesthetist** **Assistant Surgeon**	80% of PPO Allowance	60% of Usual and Reasonable Charge
Outpatient Surgery Miscellaneous, excluding not-scheduled surgery – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	80% of PPO Allowance	60% of Usual and Reasonable Charge
Rehabilitation Therapy, including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy **Habilitative Services,** covered to the extent that they are Medically Necessary **Cardiac Rehabilitation services,** limited to 36 treatment sessions per 6-month period	80% of PPO Allowance Copayment: $30	60% of Usual and Reasonable Charge Copayment: $30

Outpatient Benefits	Network Provider	Non-Network Provider
Emergency Services Expenses, emergency medical care because of a criminal sexual assault or abuse – no cost sharing	80% of PPO Allowance Copayment: $300 Copayment waived if admitted	80% of PPO Allowance Copayment: $300 Copayment waived if admitted
In-Office Physician's Visits	100% of PPO Allowance Copayment: $30	60% of Usual and Reasonable Charge Copayment: $30
Mental Health Disorder (Deductible Waived)	100% of PPO Allowance Copayment: $30	80% of Usual and Reasonable Charge Copayment: $30
Substance Use Disorder (Deductible Waived)	100% of PPO Allowance Copayment: $30	80% of Usual and Reasonable Charge Copayment: $30
Urgent Care Centers or Facilities	100% of PPO Allowance Copayment: $50	60% of Usual and Reasonable Charge Copayment: $30
Diagnostic X-ray Services	80% of PPO Allowance	60% of Usual and Reasonable Charge
Laboratory Procedures (Outpatient) (Deductible Waived)	80% of PPO Allowance	60% of Usual and Reasonable Charge
Allergy Testing and Treatment Benefit	80% of PPO Allowance	60% of Usual and Reasonable Charge
Prescription Drugs (Deductible Waived)	***At pharmacies contracting with the HealthSmart Rx®*** 100% of PPO Allowance after a $15 Copayment per Generic Drug $35 Copayment per Preferred Brand Drug $50 Copayment per Brand Drug $50 Copayment per Specialty Drug	60% of Usual and Reasonable Charge
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of PPO Allowance	60% of Usual and Reasonable Charge
Home Health Care Expenses	80% of PPO Allowance	60% of Usual and Reasonable Charge
Hospice Care Coverage	80% of PPO Allowance	60% of Usual and Reasonable Charge
Private Duty Nursing	80% of PPO Allowance	60% of Usual and Reasonable Charge
Chiropractic Care	80% of PPO Allowance Copayment: $30	60% of Usual and Reasonable Charge Copayment: $30
Other Benefits	**Network Provider**	**Non-Network Provider**
Ambulance Service	80% of PPO Allowance	80% of PPO Allowance *(subject to in-network deductible)*
Durable Medical Equipment	80% of PPO Allowance	60% of Usual and Reasonable Charge
Maternity Benefit	Same as any other Covered Sickness	

Other Benefits	Network Provider	Non-Network Provider
Routine Newborn Care	Same as any other Covered Sickness	
Gender Reassignment Surgery	Same as any other Covered Sickness	
Consultant Physician Services, when requested by the attending physician	80% of PPO Allowance Copayment: $30	60% of Usual and Reasonable Charge Copayment: $30
Additional Surgical Opinion upon request by Insured Person	100% of PPO Allowance	*100% of Usual and Reasonable Charge*
Accidental Injury Dental Treatment	80% of PPO Allowance	80% of Usual and Reasonable Charge
Abortion Expense	80% of PPO Allowance	60% of Usual and Reasonable Charge
Pediatric Dental Care Benefit, Preventive Dental care-limited to 1 dental exam every 6 months The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care: Emergency Dental Clinical Oral Evaluations Endodontic Services Periodontal Services Prosthodontic Services Medically Necessary Orthodontic Care ***Pediatric Dental Care Benefit*** *for Insured Persons up to age 19.*	See Benefit for limitations 100% of PPO Allowance- Network Provider 100% of Usual and Reasonable Charge- Non-Network Provider 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable	
Pediatric Vision Care Benefit, Limited to 1 visit per Policy Year and 1 pair of prescribed lenses and frames ***Pediatric Vision Care Benefit*** *for Insured Persons who are age 18 and under.*	100% of PPO Allowance for Preventive Services	60% of Usual and Reasonable Charge
Naprapathic Service	80% of PPO Allowance	60% of Usual and Reasonable Charge
Non-Emergency Treatment outside the United States	80% of PPO Allowance	60% of Usual and Reasonable Charge
Oral Surgery/Temporomandibular Joint Dysfunction (TMJ) Benefit	80% of PPO Allowance	60% of Usual and Reasonable Charge
Hearing Aid Benefit	80% of PPO Allowance	60% of Usual and Reasonable Charge
Routine Eye Exam for Adults	80% of PPO Allowance	60% of Usual and Reasonable Charge
Treatment of Pediatric Autoimmune Neuropsychiatric Disorders	80% of PPO Allowance	60% of Usual and Reasonable Charge
Immune Gamma Globulin Therapy	80% of PPO Allowance	60% of Usual and Reasonable Charge
Mandated Benefits	**Network Provider**	**Non-Network Provider**
Habilitative Services for Children	Same as any other Habilitative Service	
Shingles Vaccine For Insureds age 60 or older	Same as any other Preventive Service	
Infertility Treatment up to 4 treatments **Additional 2 treatments following a live birth**	Same as any other Covered Sickness	
Post-Mastectomy Care	Same as any other Covered Sickness	
Reconstructive Breast Surgery	Same as any other Surgical benefit	
Routine Care During Clinical Cancer Trials Benefit	Same as any other Covered Sickness	

Mandated Benefits	Network Provider	Non-Network Provider
Routine Care During Clinical Cancer Trials Benefit	Same as any other Covered Sickness	
Diabetes Management Benefit	Same as any other Covered Sickness	
Amino Acid-based Elemental Formula Benefit	Same as any other Covered Sickness	
Adjunctive Services in Dental Care Benefit	Same as any other Covered Sickness	
Autism Spectrum Disorders Benefit	Same as any other Covered Sickness	
Breast Cancer Pain Medication and Therapy Benefit	Same as any other Prescription Drug	
Multiple Sclerosis Preventive Physical Therapy Benefit	Same as any other Covered Sickness	
Mammography and Clinical Breast Examination	Same as any other Preventive Service	
Prosthetic and Customized Orthotic Devices	Same as any other Covered Sickness	

Definitions

Accident means a sudden, unforeseeable event that causes Injury to an Insured Person. The Accident must occur while coverage is in effect for the Insured Person.

Ambulance Service means transportation to a Hospital by an Ambulance Service.

Anesthetist means a Physician or nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Brand Name Drugs means drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

Coinsurance means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

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

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Copayment means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

- Temporarily residing; and
- Actively engaged in education or educational research related activities sponsored by the National Association for foreign Student Affairs or its Member Organizations.

Definitions continued

Covered Injury means a bodily injury that is:

- Sustained by an Insured Person while they are insured under the Policy or the School's prior policies; and
- Caused by an accident.

Coverage under the School's policies must have remained continuously in force:

- From the date of Injury; and
- Until the date services or supplies are received, for them to be considered as a Covered Medical Expense under the Policy.

Covered Medical Expense means those charges that are:

- Not in excess of the PPO Allowance for any Medically Necessary treatment, service, or supplies that are received from Network Providers;
- Not in excess of the Usual and Reasonable charges for any Medically Necessary treatment, service, or supplies are received from Non-Network providers;
- Not in excess of the charges that would have been made in the absence of this insurance;
- Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which:

- causes a loss while the Policy is in force; and
- which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Policy. The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

Dependent means:

- An Insured Student's lawful spouse or lawful domestic partner or civil union partner. A domestic partnership or civil union partnership may be between a same sex or different sex couple. The partnership is subject to all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples;
- An Insured Student's dependent biological or adopted child or stepchild under age 26; and
- An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
  - primarily dependent upon the Insured Student for support and maintenance; and
  - incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

    Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when a Insured Student enrolls a new disabled child under the plan.

Elective Surgery or Elective Treatment means surgery or medical treatment that is:

- not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and
- which occurs after the Insured Person's effective date of coverage.

Elective Treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Definitions continued

Eligible Student means a student who meets all enrollment requirements of the School named as the Policyholder in the Insurance Information Schedule.

Emergency Medical Condition means a medical condition which:

- manifests itself by acute symptoms of sufficient severity (including severe pain); and
- causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in:
  - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

Essential Health Benefits mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:

- 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.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

Generic Drugs means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

Habilitation/Habilitative Services means health care services that help the Insured Person keep, learn, or improve skills and functions for daily living. Habilitative Services may include such services as physical therapy, occupational therapy, and speech therapy.

Home Country means the Insured Student's country of citizenship. If the Insured Student has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the United States. The Insured Student's Home Country is considered the Home Country for any dependent of an Insured Student while insured under the Policy.

Hospital means an institution that:

- Operates as a Hospital pursuant to law;
- Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
- Provides 24-hour nursing service by Registered Nurses on duty or call;
- Has a staff of one or more Physicians available at all times; and
- Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

Hospital does not include the following:

- Convalescent homes or convalescent, rest or nursing facilities;
- Facilities primarily affording custodial, educational, or rehabilitant care; or
- Facilities for the aged.

Definitions continued

Hospital Confined or Hospital Confinement means a stay of eighteen (18) or more consecutive hours as a resident bed patient in a Hospital.

Immediate Family Member means the Insured Person and his or her spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

Insured Person means an Insured Student or dependent of an Insured Student while insured under the Policy.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under the Policy.

International Student means an international student:

- With a current passport and a student Visa;
- Who is temporarily residing outside of his or her Home Country; and
- Is actively engaged, on a full time basis, as a student or in educational research activities through the Policyholder.

In so far as the Policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

Loss means medical expense caused by an Injury or Sickness which is covered by the Policy.

Medically Necessary means medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The Insured Person's health care provider determines if the medical treatment provided is medically necessary.

Mental Health Disorder means a condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Out-of-pocket Expense Limit means the amount of expenses that an Insured Person is responsible for paying.

Physician means a:

- Doctor of Medicine (M.D.); or
- Doctor of Osteopathy (D.O.); or
- Doctor of Dentistry (D.M.D. or D.D.S.); or
- Doctor of Chiropractic (D.C.); or
- Doctor of Optometry (O.D.); or
- Doctor of Podiatry (D.P.M.); or
- Doctor of Naprapathy (D.N);

who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered.

A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician.

The term Physician does not mean any person who is an Immediate Family Member.

Definitions continued

PPO Allowance means the amount a Network Provider will accept as payment in full for Covered Medical Expenses.

Preferred Brand Drug means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list.

Private Duty Nursing Services means services that cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers.

School or College means the college or university attended by the Insured Student.

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of a Physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.) and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Usual and Reasonable means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:

- Like service by a provider with similar training or experience; or
- Supply that is identical or substantially equivalent.

Visa, in so far as the Policy is concerned, means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

We, Us, or Our means National Guardian Life Insurance Company or its authorized agent.

Exclusions and Limitations

Except as specified in the Policy, coverage is not provided for loss or charges incurred by or resulting from:

- **International Students Only** - Eligible expenses within the Insured Person's Home Country or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
- dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth or as provided by the Pediatric Dental Care Benefit.
- professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
- services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
- services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or as provided by the Pediatric Vision Care Benefit.
- flat feet, corns, calluses.
- treatment or removal of sleep disorders including the testing for same.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
- any expenses in excess of Usual and Reasonable charges.
- loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
- expenses payable under any prior Policy which was in force for the person making the claim.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- charges incurred for acupuncture in any form , except to the extent provided in the Schedule of Benefits.
- expenses for hair growth or removal.
- expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses, except as required for repair caused by a Covered Injury.
- racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
- expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - For the purposes of this provision, **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.

Exclusions and Limitations continued

- For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

- an Insured Person's:
  - committing or attempting to commit a felony,
  - being engaged in an illegal occupation, or
  - participation in a riot.
- durable medical equipment except as specifically provided in the Schedule of Benefits.
- custodial care service and supplies.
- expenses that are not recommended and approved by a Physician.

Academic Emergency Services

The following services are not part of the Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by GeoBlue.

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your Student Health Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small. For more details, go to ***saic.myahpcare.com.***

Important Notice

This information provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued in the state in which the Policy was delivered. Complete details may be found in the Policy on file at your school's office. The Policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

Privacy Disclosure

Under HIPAA's Privacy Rule, we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the NGL HIPAA Privacy Notice upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605 or call 1-855-844-3023. You may also view and download a copy from the website at: ***saic.myahpcare.com*.**

Summary of Benefits and Coverage

The Affordable Care Act requires all health insurers to provide consumers with a **Summary of Benefits and Coverage (SBC).** The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your insurance Policy. To obtain an SBC for your Policy, please go to ***saic.myahpcare.com*.**

Claim Procedure

In the event of Injury or Sickness, the student should:

1) Report to the Student Health Center for treatment or when not in school, to your Doctor or Hospital. Covered Persons should go to a participating Doctor or Hospital for treatment if possible.

IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.

2) Mail to the address below all prescription drug receipts (for providers outside of those contracting with HealthSmart RX®) medical and hospital bills along with patient's name and Insured student's name, address, Social Security Number, Student/Member ID and name of the University under which the student is Insured.

3) File claims within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Submit all Claims or Inquiries to:

Cigna Healthcare
P.O. Box 188061
Chattanooga, TN 37422-8061

Medical Providers Call: 1-844-545-9492

All Other Calls: 1-855-844-3023

Plan Administered by:

Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, Texas 76034-1605
1-855-844-3023
Fax 1-855-858-1964
www.ahpcare.com

For more information about this plan please visit:
saic.myahpcare.com