AIG

STUDENT HEALTH INSURANCE PLAN 2014-2015

Marywood UNIVERSITY

("the Policyholder")

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

Administrator Policy # CHH8050835
Underwriter Reference # CAS9497298

NOTE

This brochure is a brief description of the coverage available under policy series S30749NUFIC-PPO-PA. The Policy on file at the University contains all of the definitions, reductions, limitations, exclusions and termination provisions of your insurance benefits. Full details of coverage are contained in the Policy. If any discrepancy exists between this brochure and the Policy, the Policy will govern. Travel Assistance services provided by Travel Guard. Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.

Visit us on the Web:
www.BollingerColleges.com/Marywood

ELIGIBILITY All full-time undergraduate students (maintaining at least 12 credits) and graduate students (maintaining at least 6 credits) are required to have health insurance. Full-time students entering Marywood University in the Fall semester will be automatically enrolled in and charged premium on their tuition bill for the annual term of coverage under the Marywood University Student Health Insurance Plan ("the Plan"), unless coverage under the Plan is waived by providing proof of comparable health insurance coverage by the waiver deadline of **September 30, 2014.** Newly entering students in the Spring/Summer semester will be automatically enrolled in and charged premium on their tuition bill for the Spring/Summer semester term of coverage under the Plan unless coverage under the Plan is waived by providing proof of comparable health insurance coverage by the waiver deadline of **February 14, 2015.**

WAIVER AND DEPENDENT ENROLLMENT PROCESS

Students who are currently insured by another comparable health insurance plan may waive out of the Marywood University Student Health Insurance Plan with proof of such comparable coverage:

Go to the "Student Services" link on the Marywood University homepage. You will then access the Student Health Insurance Plan website at www.BollingerColleges.com/Marywood. Go to the "Request a Waiver" link and follow the instructions carefully. Once you've completed all the steps in the "Request a Waiver" link, you will be given a confirmation page that you can print out for your records.

Bollinger Specialty Group must receive the online waiver request **by the above waiver deadlines or the premium charge will remain on your tuition bill.**

An eligible student must actively attend classes at the Policyholder's school for the first 30 days of the period for which he or she is enrolled. Students who withdraw after such 30 days will remain covered under the Plan and no refund will be made.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility under another creditable coverage. Proof of ineligibility under another creditable coverage plan must be provided at time of enrollment. To enroll, please contact Bollinger Specialty Group at 1-855-338-8015.

Eligible students may also enroll their eligible Dependents. A Dependent may become eligible for coverage under the Plan only when the student becomes eligible; or within 31 days of marriage, birth or adoption. Dependents must be enrolled for the same term of coverage for which the Covered Student is enrolled.

The Dependent enrollment deadline for the Fall semester, for the annual term of coverage, is **September 30, 2014.** The Dependent enrollment deadline for newly entering students in the Spring/Summer semester is **February 14, 2015.**

To enroll a Dependent in the Plan, please contact Bollinger Specialty Group directly at 855-338-8015.

TERMS OF COVERAGE

The Policy becomes effective at 12:01 a.m. on August 25, 2014 and will terminate at 12:01 a.m. on August 25, 2015. The coverage of an eligible student who enrolls for coverage under the Policy shall take effect at 12:01 a.m. on the latest of the following dates: (1) the Policy effective date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Company; (3) the date the Policyholder's term of coverage begins; or (4) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder. Insurance will end for the Covered Student at 12:01 a.m. on the first of these to occur: a) the date the Policy terminates; b) the last day for which any required premium has been paid; or c) the date on which the Covered Student withdraws from the school because of: (1) entering the armed forces of any country (premiums will be refunded on a pro-rata basis less any claims paid) when written request is made within 90 days of leaving school; or (2) withdrawal from school during the first 30 days of the period for which enrollment was made.

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

COST OF INSURANCE*

Term of Coverage	Annual 8/25/14 – 8/25/15	Spring/Summer 1/1/15 – 8/25/15
Student Only	$1,670	$1,077
Each Dependent	$2,307	$1,573

*includes taxes and administrative fees

SCHEDULE OF BENEFITS

	IN NETWORK	OUT OF NETWORK
Aggregate Maximum Amount per Policy Year	Unlimited	
Out of Pocket Limit This is a benefit that will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit shown. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable due to Covered Percentages less than 100%. The Out- of-Pocket Limit does not include charges in excess of Reasonable and Customary; expenses incurred for prescription drugs; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy. When the Out-of-Pocket Limit becomes applicable to a Covered Person during a Policy Year, Covered Percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person for the remainder of that Policy Year up to any benefit maximum that may apply.	$5,000 per Covered Person per Policy Year $10,000 per family per Policy Year	$5,000 per Covered Person per Policy Year $10,000 per family per Policy Year
Deductible Amount per Policy Year	$250	$500
INPATIENT BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
Daily Room & Board Expense, semi-private room rate	80% of AC	60% of R&C
Miscellaneous Hospital Expense, includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays, (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses. Subject to a $150 Co-payment per Hospital admission	80% of AC	60% of R&C
Physiotherapy	80% of AC	60% of R&C
Surgical Expense	80% of AC	60% of R&C
Anesthetist	80% of AC	60% of R&C
Doctor's Visits (Doctor other than a Doctor who performed surgery or administered anesthesia)	80% of AC	60% of R&C
Alcoholism & Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness
Psychiatric Conditions Expense	80% of AC	60% of R&C

OUTPATIENT BENEFITS	IN NETWORK	OUT OF NETWORK
Day Surgery Facility / Miscellaneous, when scheduled surgery is performed in a Hospital / outpatient facility / ambulatory surgical center, including use of operating room, x-ray examinations and laboratory tests (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding physiotherapy or take home drugs and medicines)	80% of AC	60% of R&C
Surgical Expense	80% of AC	60% of R&C
Anesthetist	80% of AC	60% of R&C
Doctor's Visits (Not applicable when related to surgery)	80% of AC	60% of R&C after a $15 Co-payment
Hospital Emergency Room / Non-Scheduled Surgery Co-payment is waived if admitted	80% of AC after a $150 Co-payment	80% of R&C after a $150 Co-payment
Urgent Care	80% of AC	60% of R&C
Skilled Nursing Facility	Same as any other Sickness	Same as any other Sickness
Rehabilitative Care (physical therapy, occupational therapy, chiropractic, cardiac/pulmonary)	80% of AC	60% of R&C
Laboratory and X-rays Examinations	80% of AC	60% of R&C
CAT Scan/MRI/PET Scan	80% of AC	60% of R&C
Diagnostic Services and medical procedures performed by the Doctor (other than Doctor's visits, physiotherapy, x-rays and lab procedures).	80% of AC	60% of R&C
Radiation Therapy and Chemotherapy	80% of AC	60% of R&C
Prescribed Medicines Expense – prescriptions must be filled at a Catamaran participating pharmacy. For a list of nationwide participating pharmacies, please visit www.mycatamaranrx.com. The Co-payment will be waived for all prescribed FDA-approved birth control.	Co-payment per prescription – limited to a 30 day supply: $15 Generic $35 Formulary Brand Name $50 Non-Formulary Brand Name	
Alcoholism and Substance Abuse Expense	80% of AC	60% of R&C
Psychiatric Conditions Expense	80% of AC	60% of R&C

OTHER SERVICES	IN NETWORK	OUT OF NETWORK
Pediatric Dental Treatment Expense (for Covered Persons under age 19 only): Oral exam limited to 2 per Policy Year **Covered Percentage:** Preventive Services Basic Services Major Services Orthodontic Services Co-payment Amount per visit	 80% of AC 60% of AC 50% of AC 50% of AC $25	 80% of R&C 60% of R&C 50% of R&C 50% of R&C $25

Pediatric Vision Care Expense (for Covered Persons under age 19 only): One exam per Policy Year and one set of lenses and frames per Policy Year		
Co-payment amount per visit:		
• Examination	$25	$25
• Materials	$25	$25
Covered Percentage	80% of AC	80% of R&C
Standard Plastic Lenses		
• Single Vision	$25 Maximum	$25 Maximum
• Bifocal	$25 Maximum	$25 Maximum
• Trifocal	$25 Maximum	$25 Maximum
• Lenticular	$25 Maximum	$25 Maximum
• Progressive	$25 Maximum	$25 Maximum
Frames / Contact Lenses (in lieu of eyeglass lenses and frames)	$150 Maximum	$150 Maximum
Fit, Follow-up and Materials:		
-Effective	$25 Maximum	$25 Maximum
-Medically Necessary	$50 Maximum	$50 Maximum
Vision Care Expense (For Covered Persons age 19 and older): One routine exam every 24 months and one set of lenses and frames per Policy Year.		
Maximum Amount per Policy Year: $750		
Co-payment amount per visit:		
• Examination	$25	$25
• Material	$25	$25
Covered Percentage	50% of AC	50% of R&C
Standard Plastic Lenses		
• Single Vision	$25 Maximum	$25 Maximum
• Bifocal	$25 Maximum	$25 Maximum
• Trifocal	$25 Maximum	$25 Maximum
• Lenticular	$25 Maximum	$25 Maximum
• Progressive	$25 Maximum	$25 Maximum
Frames / Contact Lenses (in lieu of eyeglass lenses and frames)	$100 Maximum	$100 Maximum
Fit, Follow-up and Materials:		
-Effective	$25 Maximum	$25 Maximum
-Medically Necessary	$50 Maximum	$50 Maximum

Preventive Services, as mandated by the Patient Protection and Affordable Care Act	100% of AC (not subject to Deductible or Co-payment)	60% of R&C
Ambulance Services Expense	100% of R&C	
Consultant's Fees Expense (must be requested and ordered by the attending Doctor)	80% of AC	60% of R&C
Durable Medical Equipment and Orthopedic Appliance	80% of AC	60% of R&C
Dental Treatment (Injury Only) : $500 maximum per Injury	80% of AC	60% of R&C
Maternity	80% of AC	60% of R&C
Home Health Care Expense	80% of AC	60% of R&C
Hospice Care Expense	80% of AC	60%of R&C
Accidental Death and Dismemberment Benefit	$1,000 principal sum	$1,000 principal sum

DEFINITIONS

Whenever used in the Policy:

"Accident" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

"Actual Charge" means the charge for the covered service by the provider who furnishes it.

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

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

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

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

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

The term "child" includes:

(a) a legally adopted child;

(b) a child who has been placed for purposes of adoption in the Covered Student's or spouse's home pending adoption procedures, from the moment of placement; and

(c) a step-child if such child depends on the Covered Student or spouse for full support.

"Placement for purposes of adoption" means the assumption and retention by the Covered Student of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the Covered Student terminates upon termination of such legal obligation. Coverage is not contingent upon whether a final adoption order is ever issued. "Child" here means an individual less than 19 years of age as of the date of adoption or placement for adoption.

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

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

Elective treatment includes, but is not limited to: breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum; and treatment of infertility.

"Eligible Expense" as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) not in excess of the charges based on the Policyholder's list of covered medical treatment, services and supplies that are provided and billed by the Policyholder and approved by the Company; (d) with respect to the Preferred Provider, is the Allowable Charge; (e) is the negotiated rate, if any; and (f) incurred while the Policy is in force as to the Covered Person.

"Emergency Medical Condition" means a Sickness or Injury for which 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:

(a) the Covered Person's life could be in serious jeopardy;
(b) bodily functions would be seriously impaired; or
(c) a body organ or part would be seriously damaged; or
(d) serious disfigurement; or
(e) serious jeopardy to the health of the fetus.

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

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

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

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

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

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

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

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

A service or supply will not be considered as Medically Necessary if:

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

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

"Preventive Services" mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

"Reasonable and Customary" ("R&C") means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

"Geographic area" means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

"Urgent Condition" means a sudden illness, Injury, or condition, that:

(a) is severe enough to require prompt medical attention to avoid serious deterioration of the Covered Person's health;
(b) includes a condition which would subject the Covered Person to severe pain that could not be adequately managed without urgent care or treatment;
(c) does not require the level of care provided in the emergency room of a Hospital; and
(d) requires immediate outpatient medical care that cannot be postponed.

"Urgent Condition" includes, but is not limited to: small cuts or wounds that may require stitches; sprains, strains or deep bruises; mild to moderate asthma attacks; earaches or ear infections; upper respiratory infections; colds, coughs and congestion; diarrhea; sore throats; insect bites; headache; menstrual or muscle cramps; minor burns; minor swelling; sudden or chronic backache; dizziness; abdominal pains; and rashes.

EXCLUSIONS AND LIMITATIONS

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

1. as a result of dental treatment, except as provided elsewhere in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
2. for eye examinations, eyeglasses, contact lenses, or prescription for such except as as specifically provided in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
3. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
4. for Injury or Sickness resulting from war or act of war, declared or undeclared.
5. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
6. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
7. for cosmetic surgery, except as required to correct an Injury for which benefits are otherwise payable under the Policy or as specifically provided for in the Policy. "Cosmetic surgery" shall not include reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
8. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot or civil commotion.
9. for Elective Treatment or elective surgery; voluntary or elective abortions except as specifically provided in the Policy.
10. for any services rendered by a Covered Person's immediate family member.
11. for any treatment, service or supply which is not Medically Necessary.
12. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
13. for loss due to voluntary use of any drug, narcotic or controlled substance, unless prescribed by a Doctor.
14. for Injury or Sickness caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage of or for the purpose as prescribed by the Covered Person's Doctor.
15. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports; skiing.
16. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
17. for Injury resulting from fighting, except in self-defense.

FIRST HEALTH PREFERRED PROVIDER NETWORK

Covered Persons insured under the Plan may choose to be treated within or outside of the First Health Preferred Provider Organization ("PPO"). Reimbursement rates will vary according to the source of care as described under the Schedule of Benefits. Assignment of a PPO Provider does not guarantee eligibility or right to student health benefits. **It is the Covered Person's responsibility to verify that a provider is a Participating Provider prior to services being rendered.** Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or the facility to which the Covered Person is referred is also a PPO provider. For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the Out of Network level. If treatment or care is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the In Network level. Benefits payable under the Plan for covered services rendered through the PPO network shall be based on the Allowable Charges of its providers. Benefits payable under the Plan for covered services rendered outside the PPO network shall be based on the Reasonable and Customary charges of the providers. To locate a PPO Provider, please call1-800-226-5116 or visit www.MyFirstHealth.com.

STUDENT HEALTH SERVICES REFERRAL PROCEDURE - STUDENTS ONLY

The Deductible Amount will be waived when, for Covered Students Only, a referral is made by a Student Health Service Doctor. A referral from the Student Health Services is therefore recommended before benefits are payable. This provision does not apply*: (a) if the Student Health Services is closed; (b) if the covered service is rendered at another facility during school breaks or vacation times; (c) if medical care is received when student is more than 50 miles from campus; (d) if medical care is obtained by a student who is not eligible to use the Student Health Services; (e) for maternity; (f) for mental disorders; (g) for annual routine gynecological/obstetrical services; or (h) for an Emergency Medical Condition. Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or non-PPO provider. This referral requirement does not apply to the Covered Student's Dependents.

*The applicable Deductible shall apply to all of the exceptions to the referral provision shown above.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Company will pay the benefit below for Injuries to a Covered Person:

(a) caused by an Accident which happens while covered by the Policy; and

(b) which directly, and from no other cause, result in any of the losses listed below within 365 days of the Accident that caused the Injury. This does not apply to loss of life.

The amount of this benefit is shown in the table below:

For Loss of	Percentage of Maximum Amount
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
The Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means the total, irrevocable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

"Severance" means the complete separation and dismemberment of the part from the body.

COORDINATION OF BENEFITS PROVISION

The Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health care coverage under which the Covered Person is enrolled shall not exceed 100% of the cost of the covered services.

STATE MANDATED BENEFITS

The Plan also covers all applicable mandated benefits as required by the State of Pennsylvania. Please see the Policy on file with the University for full details.

CLAIM PROCEDURE

In the event of an Injury or Sickness, the Covered Person should:

1. Notify Bollinger Specialty Group within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible. Complete the Bollinger claim form in full and sign it. Mail a copy to Bollinger Specialty Group, PO Box 727, Short Hills, NJ 07078-0727.
2. Claim forms are available online at www.BollingerColleges.com/Marywood or by calling1-855-338-8015. If the providers have given you bills, please keep a copy and attach them to the claim form.
3. Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Bollinger Specialty Group. Online claim status is available at www.BollingerColleges.com/Marywood or by calling1-855-338-8015.
4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to Bollinger.

TRAVEL GUARD

DESCRIPTION OF TRAVEL ASSIST AND STUDENT ASSIST SERVICES

Procedures on How to Access Travel Guard and Student Assist Services 24-Hour Assistance Call Services

When to Contact Travel Guard:

- Before you incur expenses.
- If you are 100+ miles from home and require medical assistance or have a medical emergency.
- If you are 100+ miles from home and need assistance with a non-medical situation such as lost luggage, lost documents, legal help, etc.

How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.
- Outside the US and Canada:
  - Request an international operator.
  - Request the operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 1-262-364-2203.

Travel Guard is available 24-hours-a-day/7-days-a-week/365-days-a-year. Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help participants should the need arise while traveling. 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 Doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.
What information will you need to provide when you call:

- Advise Travel Guard of your insurance company name.
- Provide your Policy Number or School Name.
- 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.

Description of Services

General Information: Services listed below 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 & Immunization
- Weather & Exchange Rates
- Environmental & Political Warnings

Technical: Services listed below include assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & 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
- Lost/Stolen Luggage Information
- Claims-related Assistance & Personal Effects Assistance
- Lost Document Assistance & Cash Transfer Assistance
- Embassy/Consulate Information
- Telephone Interpretation
- Enroute Travel Assistance

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 physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains and insurance claims coordination.

Medical Assistance:

- Medical Referral
- Out-patient Assistance
- In-patient Assistance

Medical Transport:

- Medical Evacuation
- Repatriation of Remains

REPATRIATION OF REMAINS AND MEDICAL EVACUATION BENEFITS

(Benefits for Repatriation of Remains and Medical Evacuation are provided by National Union Fire Insurance Company of Pittsburgh, Pa.)

REPATRIATION OF REMAINS: $7,500 Maximum Amount

If a Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of Primary residence, but not exceeding the Maximum Amount per Covered Person.

Eligible Expenses include, but are not limited to: (1) embalming or cremation: (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

MEDICAL EVACUATION: $10,000 Maximum Amount

The Company will pay, subject to the limitations set out herein, for eligible Medical Evacuation expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Medical Evacuation while outside his or her home country but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes. The Doctor ordering the Medical Evacuation must certify: (a) that the severity of the Covered Person's Injury or emergency Sickness warrants his or her Medical Evacuation; and (b) the Covered Person has been Hospital confined for at least five (5) consecutive days prior to Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions.

Repatriation of Remains and Medical Evacuation benefits are subject to all Policy provisions.

STUDENT ASSIST SERVICES

Concierge Services: You receive the comfort, care, and attention of Travel Guard's Personal Assistance Coordinators available 24/7 to respond to virtually any request — large or small.

Personal Security Assistance: You can feel safe and secure with Travel Guard's Personal Security Assistance at home or while traveling. To activate personal security services, please log onto http://aig.com/travelguardassistance.

To register:

(1) Click on "Sign In" in the upper right-hand corner.
(2) Click on "Register Here".
(3) Complete required fields: first name, last name, email address, policy number 9497298 and then click "Submit."

AMERICAN HEALTH HOLDING, INC.
24-HOUR STUDENT EMERGENCY CARE HOTLINE

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free
(866) 315-8756

(American Health Holding, Inc. is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

Comprehensive Resources and Advice from Registered Nurses

- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.
- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.
- Integrated phone access to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.

THE PLAN ADMINISTERED BY:

Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

PO BOX 727
SHORT HILLS, NJ 07078
855-338-8015

PREFERRED PROVIDER NETWORK BY:

www.MyFirstHealth.com