AIG Benefit Solutions

Marywood University

(“the Policyholder”)

2015 – 2016
Student Health Insurance Plan

(“the Plan”)

Administrator Policy Number: CHH8050836
Underwriter Reference Number: CAS9149407

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

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 Group, Inc. (“Travel Guard”). Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.

AIG

Marywood
UNIVERSITY

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 15, 2015**. 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, 2016**.

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.

WAIVER AND DEPENDENT ENROLLMENT PROCESS

Students who are currently insured by another comparable health insurance plan may waive out of the Plan with proof of such comparable coverage.

To waive coverage under the Plan, please go to the "Student Services" link on the Marywood University homepage at www.marywood.edu. 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.

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 15, 2015**. 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 15, 2015 and will terminate at 12:01 a.m. on August 15, 2016. 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: (1) because of entering the armed forces of any country (premiums will be refunded on a pro-rata basis less any claims paid) when written request is made within 90 days of leaving school; or (2) when the withdrawal from school is during the first 30 days of the period for which the student is enrolled (a full refund of premium will be made (less any claims paid) 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.

2015 – 2016 COST OF INSURANCE*

Term of Coverage	Annual 8/15/15-8/15/16	Spring/Summer 1/1/16-8/15/16	Summer Only** 5/15/16-8/15/16
Student Only	$1,768	$1,148	$494
Each Dependent	$1,768	$1,148	$494

*includes taxes and administrative fees

**Summer semester-only coverage is available only to new, incoming students to the university for the summer semester.

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.

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

"Complications of Pregnancy" means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis; or
- eclampsia; puerperal infection; or
- RH Factor problems; or
- severe loss of blood requiring transfusion; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c)

hyperemesis gravidarum and pre-eclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy. Complications of Pregnancy also include:
- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion.)

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

“Covered Percentage” means the percentage of the Eligible Expense that is payable as a benefit under the Policy.“Covered Person” means a Covered Student and his or her Dependent(s) insured under the Policy.

“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 Spouse’s child until the date such child attains age 26.

The term “child” includes:
(a) a legally adopted child;
(b) a child who has been placed 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.

The “child” of a Covered Student or Spouse will not be denied enrollment under the Policy because he or she:
(a) was born out of wedlock;
(b) is not claimed as a dependent on the Covered Student’s or Spouse’s federal tax return;
(c) does not reside with the Covered Student or Spouse in the Policy’s service area.

“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.

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

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

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

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

“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.

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

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

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

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

Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; 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.

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

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

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

“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.
(a) Food and Drug Administration (FDA); or
(g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual or
(h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

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

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

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

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

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

"Policy Year" means the period of time measured from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

“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 Ad- ministration.

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

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

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

Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date shown in the Schedule of Benefits in the Policy on file with the Policyholder.

“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.

"Sound Natural Teeth" means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

“Spouse” means the Covered Student’s legal Spouse. The term “Spouse” wherever used in the Policy shall also mean the Covered Student’s domestic partner with whom a domestic partnership has been established attesting to the relationship with another person, providing they are living together and any applicable requirements regarding domestic partnership interdependency have been met. A domestic partnership qualifies if the partners are able to provide a domestic partnership certificate from a city, county or state which offers the ability to register a domestic partnership.

The domestic partnership must satisfy the following requirements:

1. registration as a domestic partnership or, in the case of retirees living outside the City, an alternative affidavit of domestic partnership;
2. proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof); and
3. evidence of two or more of the following:
   - (a) a joint bank account;
   - (b) a joint credit card or charge card;
   - (c) joint obligation on a loan;
   - (d) status as an authorized signatory on the partner’s bank account, credit card or charge card;
   - (e) joint ownership; of holdings or investments;
   - (f) joint ownership of residence;
   - (g) joint ownership of real estate other than residence;
   - (h) listing of both partners as tenants on the lease of shared residence;
   - (i) shared rental payments of residence (need not be shared 50/50);
   - (j) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   - (k) a common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
   - (l) shared household budget for purposes of receiving government benefits;
   - (m) status of one as representative payee for the other’s government benefits;
   - (n) joint ownership of major items of personal property (e.g., appliances, furniture);
   - (o) joint ownership of a vehicle;
   - (p) joint responsibility for child care (e.g., school documents, guardianship);
   - (q) shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
   - (r) execution of wills naming each other as executor and/or beneficiary;
   - (s) designation as beneficiary under the other’s life insurance policy;
   - (t) designation as beneficiary under the other’s retirement benefits account;
   - (u) mutual grant of durable power of attorney;
   - (v) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   - (w) affidavit by creditor or other individual able to testify to partners’ financial interdependency;
   - (x) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

FIRST HEALTH 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.

MARYWOOD UNIVERSITY 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 ("R&C"); 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. If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out-of-Pocket shown, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible medical Expense incurred by such Covered Student and his covered Dependents for the rest of that Policy Year. When the Family Out-of-Pocket Limit is reached, the Covered Percentage will be increased to 100% of the Eligible Expenses incurred for the remainder of that year.	$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 per Covered Person	$250	$500
INPATIENT BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Daily Room & Board, semi-private rate	80% of Allowable Charges ("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
Maternity	80% of AC	60% of R&C
Physiotherapy, Occupational Therapy, Cardiac/Pulmonary Therapy during Hospital Confinement	80% of AC	60% of R&C
Surgical Expense	80% of AC	60% of R&C
Anesthesia	80% of AC	60% of R&C
In-Hospital Doctor's Fees Expense (Doctor other than a Doctor who performed surgery on or administered anesthesia to the Covered Person)	80% of AC	60% of R&C
Psychiatric Conditions Expense (serious mental illness/mental and nervous disorder)	Same as any other Sickness	Same as any other Sickness
Alcoholism & Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness
OUTPATIENT BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Surgical Expense	80% of AC	60% of R&C
Anesthesia	80% of AC	60% of R&C

Day Surgery Facility / Miscellaneous, when scheduled surgery is performed in a Hospital, outpatient facility or ambulatory surgical center, including use of 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).	80% of AC	60% of R&C
Hospital Emergency Room and Non-Scheduled Surgery: For use of Hospital Emergency Room, including attending Doctor's charges, operating room, lab and x-ray examinations, supplies. The Co-payment Amount of $150 will apply to each visit to the Hospital Emergency Room unless the Covered Person is admitted to the Hospital as an inpatient.	80% of AC after a $150 Co-payment	80% of R&C after a $150 Co-payment
Preventive Services, mandated by the Patient Protection and Affordable Care Act To view a list of covered preventive services, go to http://www.healthcare.gov/preventive-care-benefits/	100% of AC (not subject to Deductible or Co-payment)	60% (subject to Deductible and Co-payment)
Allergy Testing and Serum	80% of AC	60% of R&C
Laboratory and X-rays Examinations (not otherwise covered under Preventive Services)	80% of AC	60% of R&C
CAT Scan/MRI/PET Scan	80% of AC	60% of R&C
Radiation Therapy and Chemotherapy	80% of AC	60% of R&C
Durable Medical Equipment and Orthopedic Appliance	80% of AC	60% of R&C
Orthopedic Braces and Appliances	80% of AC	60% of R&C
Diagnostic Services and medical procedures performed by the Doctor (other than Doctor visits, Physiotherapy, x-rays and lab procedures) (not otherwise covered under Preventive Services).	80% of AC	60% of R&C
Rehabilitative Services / Habilitative Services (Physiotherapy, occupational therapy, chiropractic, cardiac/pulmonary)	80% of AC	60% of R&C
Speech Therapy	80% of AC	60% of R&C
Intravenous Home Therapy	80% of AC	60% of R&C
Out of Hospital Doctor's Fees Expense Doctor (other than Specialist) Specialist* *Specialist – a Doctor whose practice is limited to a particular branch of medicine. Benefits do not apply when related to surgery or Physiotherapy. Includes infusion therapy.	 80% of AC 80% of AC	 60% of R&C after a $15 Co-payment 60% of R&C after a $15 Co-payment
Consultant's Fee Expense	80% of AC	60% of R&C
Ambulance Expense	100% of R&C	100% of R&C
Dental Treatment Expense (Injury Only): $500 maximum amount per Injury	80% of AC	60% of R&C
Pediatric Dental Treatment Expense (for Covered Persons under age 19 only): Limited to 1 dental exam and cleaning every 6 months. Covered Percentage: • Preventive Services • Basic Services • Major Services • Orthodontic Services Co-payment Amount per visit	 80% of R&C 60% of R&C 50% of R&C 50% of R&C $25	 80% of R&C 60% of R&C 50% of R&C 50% of R&C $25

Prescribed Medicines Expense – prescriptions must be filled at a Catamaran participating pharmacy. For a list of nationwide participating pharmacies, please visit www.mycatamaranrx.com. This benefit applies to all prescribed FDA-approved birth control methods. The Co-payments will be waived for 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 Drug	
Psychiatric Conditions Expense (serious mental illness/mental and nervous disorders)	Same as any other Sickness	Same as any other Sickness
Alcoholism and Substance Abuse Expense	80% of AC	60% of R&C
Vision Care Expense (For Covered Persons age 19 and older): Limited to one routine exam per 12 month period and one prescribed lens and frames in a 12 month period. Maximum Amount per Policy Year: $750 Co-payment amount per visit: • Examination • Material Covered Percentage Standard Plastic Lenses • Single Vision • Bifocal • Trifocal • Lenticular • Progressive Frames / Contact Lenses (in lieu of eyeglass lenses and frames) Fit, Follow-up and Materials: • Effective • Medically Necessary	 $25 $25 50% of R&C $25 Maximum $25 Maximum $25 Maximum $25 Maximum $25 Maximum $150 Maximum $25 Maximum $50 Maximum	 $25 $25 50% of R&C $25 Maximum $25 Maximum $25 Maximum $25 Maximum $25 Maximum $150 Maximum $25 Maximum $50 Maximum
Pediatric Vision Care Expense (for Covered Persons under age 19 only): Limited to one exam per 12 month period and one prescribed lens and frames in a 12 month period. Co-payment amount per visit: • Examination • Materials Covered Percentage Standard Plastic Lenses • Single Vision • Bifocal • Trifocal • Lenticular • Progressive Frames / Contact Lenses (in lieu of eyeglass lenses and frames) Fit, Follow-up and Materials: • Effective • Medically Necessary	 $25 $25 80% of R&C $25 Maximum $25 Maximum $25 Maximum $25 Maximum $25 Maximum $150 Maximum $25 Maximum $50 Maximum	 $25 $25 80% of R&C $25 Maximum $25 Maximum $25 Maximum $25 Maximum $25 Maximum $150 Maximum $25 Maximum $50 Maximum
Home Health Care Expense	80% of AC	60% of R&C
Hospice Care Expense	80% of AC	60%of R&C
Urgent Care Expense	80% of AC	60% of R&C
Skilled Nursing Facility	Same as any other Sickness	Same as any other Sickness

REPATRIATION OF REMAINS AND MEDICAL EVACUATION BENEFITS

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.

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was reasonably possible to contact Travel Guard in advance. Please see page 11 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

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. The Company reserves the right to determine the benefit payable, including any reductions, if it was reasonably possible to contact Travel Guard in advance. Please see page 11 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Maximum Amount: $1,000

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

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

(b) which directly, and from no other cause, result in any of the losses listed below within 365 days of the Accident that caused the Injury. 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.

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 Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
2. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
3. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a 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. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
14. 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.
15. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
16. for Injury resulting from fighting, except in self-defense.

STUDENT HEALTH SERVICES REFERRAL PROCEDURE - STUDENTS ONLY

A referral from the Student Health Center is required before benefits are payable. This provision does not apply: (a) if the Student Health Service 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 Service; (e) for maternity; (f) for mental disorders; (g) for annual routine gynecological/obstetrical services; or (h) for Emergency Medical Conditions. Benefits for 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 Dependent(s). Per 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.

The Deductible(s) Amount will be waived when, for Covered Students only, a referral is made by a Student Health Service Doctor. The applicable Deductible(s) shall apply to all of the exceptions to the referral requirement shown above.

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 Center

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.

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 nonmedical situation such as lost luggage, lost documents, legal help, etc.

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 you should the need arise while you are traveling or away from home. The Travel Guard Medical Staff consists of full-time, onsite Registered Nurses and Emergency Physicians 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 physician has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide Travel Guard 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 and 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 enroute emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage & Personal Effects Assistance
- Lost Document Assistance
- 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 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
- In-patient Assistance
- Out-patient Assistance

Medical Transport:

- Medical Evacuation
- Repatriation of Remains

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 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

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

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

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.

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 1329, Morristown, NJ 07692.
2. Claim forms are available online at www.BollingerColleges.com/Marywood or by calling1-866-267-0092. 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 calling1-866-267-0092.
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.

THE PLAN ADMINISTERED BY

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

P.O. Box 1329
Morristown, NJ 07962

1-800-526-1379

PREFERRED PROVIDER NETWORK

www.MyFirstHealth.com

STUDENT HEALTH INSURANCE

AIG, Higher Education
Website: www.studentinsurance.com
Toll Free: 1-888-722-1668

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