World Learning

Student Health Insurance Plan
2013-2014
SIT Graduate Institute

Your student health insurance coverage, offered by Monumental Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. If you have any questions or concerns about this notice, contact Bollinger Insurance Services, Short Hills, NJ, 1-866-267-0092. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Please Note: Students attending SIT Graduate Institute are automatically covered by the insurance described in this brochure.

This outline of coverage contains the essential provisions of the Plan and should be retained for reference because no Individual certificate will be issued. The Master Policy is maintained by the College.

Policy# CVT413J
Policy Form SH5000GPM

ELIGIBILITY

All degree-seeking students attending World Learning SIT Graduate Institute on a full-time basis must participate in the college's medical insurance plan. The cost of medical insurance will automatically be added to a student's bill. Students must actively attend classes for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes.

EFFECTIVE DATE OF POLICY

The Master Policy becomes effective August 25, 2013 12:01 A.M. and individual student coverage is provided during the period for which the applicable premium for that student has been paid. The Master Policy expires at 12:00 A.M. on August 25, 2014.

TERMINATION OF COVERAGE

The insurance of any Covered Person will immediately terminate on the earliest of:

(1) the date to which the premium is paid;

(2) the date this Policy expires as shown on the Schedule of Benefits, subject to the Extension of Benefits After Termination provision;

(3) the date of entrance into the armed forces of any country, a pro-rata portion of the premium paid will be returned; or

(4) the date the Covered Person no longer meets the conditions of eligibility for coverage.

Termination will be made without prejudice to any existing expense. Coverage for any Insured who leaves the College before the end of the semester will continue in force through the end of the period for which a premium was paid.

DEFINITIONS

DEDUCTIBLE means the dollar amount of Covered Medical Expenses that must be paid as an out-of-pocket expense by each Covered Person per Injury or Sickness each Policy Year before benefits are payable under this Policy. The Deductible Amount is shown on the Schedule. Under certain conditions, the Deductible Amount may be lowered or waived by the Company.

ELECTIVE SURGERY means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under this Policy. Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for: acne; accupuncture; breast implants; breast reduction; circumcision;

corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under this Policy; deviated nasal septum, including submucous resection and/or other surgical correction; fertility tests; hair growth or removal; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities except for prescription drugs prescribed by a physician to treat such disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind) with the exception of screening, counseling or behavioral interventions for the treatment of obesity and except for the treatment of an underlying covered Sickness; premarital examinations; sexual reassignment surgery , skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; tubal ligation; vasectomy; and weight loss or reduction.

INJURY means bodily Injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under this Policy. A Covered Person must begin receiving services, supplies or treatment within 72 hours from the time of accident in order for it to be considered a covered Injury. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICALLY NECESSARY means care which a Physician has determined to be certifiably essential for the diagnosis or treatment of a Sickness or Injury. This determination must be based on objective results produced by an examination of the Covered Person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on us and the Insured.

OTHER VALID and COLLECTIBLE MEDICAL INSURANCE includes but is not limited to group insurance; automobile medical payments and no-fault insurance; individual major medical policies; coverage provided by a Hospital or medical service organization; union welfare plans; or employer or employee benefits organization; or employer's liability coverage.

SICKNESS means an illness, or disease , or trauma related disorder due to Injury which first manifests or causes a loss while this Policy is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes Pregnancy and Complications of Pregnancy.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Insured's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Insured was medically diagnosed, treated (including medication), or advised by a Physician within the six months immediately prior to his Effective Date of Coverage under this Policy. Covered Medical Expenses resulting from a Pre-existing Condition will not be covered unless:

(1) six consecutive months have elapsed during which no medical treatment or advice is given by a physician for such condition; or
(2) the Insured has been insured under this Policy and the University's prior policies for twelve months; or
(3) The insured has been receiving benefits under the University's prior policies and has been continuously insured since the date of accident, Injury, or Sickness, whichever occurs first.

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFIT
CAREMARK

After a copayment of $10 for generic, $25 for a brand name, or $50 for specialty drug, per prescription, the cost of prescription drugs is payable up to the policy maximum benefit allowed.

Prescriptions must be filled at a Caremark Participating Pharmacy. Insured Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage.

Before you receive your insurance ID card, if you need to have a prescription filled, go to any participating pharmacy, pay for the medication in full and save the receipt. Your insurance ID card will include instructions on how to file for reimbursement for prescriptions filled before you received your card. Reimbursement will be at the Caremark contracted discount rate and will be less than the rate charged by the pharmacy. After you receive your insurance ID card, no claim forms need be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations at 1-866-284-9266. This number is effective for enrolled members only. You will need the group number and member number printed on the card.

PREFERRED PROVIDER NETWORK
FIRST HEALTH

The Health Insurance Plan utilizes the First Health Network. While you may utilize any provider you choose, you will decrease your out-of-pocket expenses if you receive care locally and nationally through First Health Network which provides access to hospitals and health care providers through its Network. However, you are not required to go to a Preferred Provider as use of this network is strictly optional.

There are advantages to using a Network Provider, and consequently out-of-pocket expenses will be less based on a Preferred Allowance, which means that Network Providers have agreed to accept a predetermined fee as payment for their services. The Insured Person should be aware that Network Provider Hospitals may be staffed with Out-of-Network Providers. Receiving services or care from an Out-of-Network Provider at a Network Hospital does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Doctors are Network Providers. The best way to identify Preferred Providers is when calling for an appointment or at the time of service, or by contacting the First Health Network at their toll free number at 1-800-226-5116 or visit their website at www.MyFirstHealth.com.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

For Accidental Death or Dismemberment occurring within 90 days from the date of a covered accidental bodily Injury, the Company will pay, in addition to the medical expense benefits provided herein, one of the following (the largest applicable amount):

Accidental Death	$5,000.00
Both Hands, Feet or Eyes	$5,000.00
One Hand and One Foot	$ 5,000.00
One Hand and Sight of One Eye	$ 5,000.00
One Hand and Sight of One Eye	.$5,000.00
One Hand or Foot or Sight of One Eye	$2,500.00

BASIC INJURY AND SICKNESS MEDICAL EXPENSE BENEFITS

If, on account of Injury or Sickness, the Insured shall incur Medical Expenses commencing within 60 days from the date of Injury or Sickness, the Company will pay 80% In Network and 60% Out of Network of the Usual and Customary (U&C) charges for covered expenses actually incurred as the result of such Injury or Sickness to a maximum of $500,000.00, subject to a copay of $10 for each visit to a physician (in or out of network). Under this plan, there is a $500 deductible (per covered person per Policy Year) for In Network providers and a $1,000 deductible (per covered person per Policy Year) for Out of Network providers. Reimbursement for daily hospital room and board expenses incurred may not exceed the usual semi-private room charge made by the servicing hospital. For an in-patient hospital stay, there will be a $150.00 co-pay for all covered services provided during the in-hospital stay.

ADDITIONAL BENEFITS

Expenses incurred for psychiatric care on an in-patient or out-patient basis will be reimbursed at 80% In Network and 60% Out of Network

Coverage for Medically Necessary expenses related to quarantine where required locally or overseas as a direct result of a Sickness. 80% In Network and 60% Out of Network of charges for immunizations required for overseas travel after you are actively enrolled in a program, but does not include immunizations before the program start date. Expenses incurred for Substance Dependency/Abuse on an inpatient/outpatient basis are paid as per state mandate.

MATERNITY EXPENSE BENEFIT

Benefits are payable at 80% In Network and 60% Out of Network for expenses incurred for inpatient care for mother and newborn in a health care facility for (1) 48 hours following an uncomplicated vaginal delivery or (2) 96 hours following an uncomplicated delivery by cesarean section. Benefits are payable for the Usual and Customary Charge for expenses incurred for timely postdelivery care in the mother's home, provider's office, or health care facility, if mother or newborn is discharged from inpatient care before the expiration of the Maximum hours of inpatient care. Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. It includes parent education, assistance with training in breast feeding and bottle feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care is determined in accordance with recognized medical standards for that care.

NEWBORN COVERAGE BENEFIT

Coverage for a Covered Person's newborn child will be effective from the moment of birth. Coverage will include any needed care or treatment for medically diagnosed congenital defects or birth abnormalities. Notification and additional premium for a newborn child must be received by the Company within 31 days after the child's birth for coverage to continue beyond this 31 day period. If the additional premium is not paid, the benefit for the first 31 days will be paid as shown on the schedule.

MANDATED BENEFITS

The plan will pay for the following mandated benefits and any other applicable mandate in accordance with Vermont insurance laws: Chiropractic Benefit; Chemotherapy Benefit; Diabetes Supplies, Equipment and Self-Management Training Benefit; Inherited Metabolic Disease Benefit; Cancer Clinical Trials Benefit; Telemedicine Services; Contraceptives Benefit; Mammography; Independent External Review; Maternity Benefit; Midwife Coverage, Home Birth; Temporomandibular Joint Dysfunction (TMJ); Prescription Drugs Purchased and Used in Canada; Mental Health, Alcohol or Substance Abuse Treatment; Live Organ Donor Coverage; Colorectal Cancer Screening; Orally Ad-

ministered Anti-Cancer Medication Benefit; Early Childhood Developmental Disorders; Anesthesia for Certain Dental Procedures Benefit; and Tobacco Cessation Program.

ADDITIONAL BENEFITS

In addition to the mandated coverage we will provide coverage for the following: Coverage for Bone Marrow Transplants; Benefits for Anesthesia and Hospitalization for Dental Procedures; Emergency Services, Cancer Screening Tests; Diabetes Equipment, Supplies, and Services; Maternity Benefits: and Metabolic Disorders.

NON-DUPLICATION OF BENEFITS

This Policy provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any Other Valid and Collectible Insurance. If the Covered Person is covered by Other Valid and Collectible Insurance, all benefits payable by such insurance in excess of $2,000 will be determined before benefits will be paid by this Policy. This Policy is the second payor to any other insurance having primary status or no coordination or non-duplication of benefits provision. If the Covered Person is insured under group or blanket insurance which is also excess to other coverage, this Policy pays a maximum of 50% of the benefits otherwise payable. Benefits paid by this Policy will not exceed: (1) any applicable Policy maximums; and (2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

COORDINATION OF BENEFITS

EXPLANATION When a person is covered by more than one Plan, the benefits that are paid will be shared between the Plans. This is done so that the total benefits paid will not be more than 100 percent of the Allowable Expenses for any Covered Person.

In a Policy Year this Policy will pay:

(1) its regular benefits in full; or

(2) a reduced amount of benefits if a Covered Person is covered under more than one Plan. If a reduced amount of benefits is paid using this provision, each benefit that would be payable in the absence of this provision:

  a) will be reduced to the same proportion; and

  b) the reduced amount will be charged against any benefit limit of this Policy that applies.

MEDICAL EVACUATION BENEFIT

Upon receipt of due proof that a Covered Person incurred expenses for Physician ordered emergency medical evacuation, including medically appropriate transportation and Medically Necessary Care en route to the nearest suitable hospital or a facility operated pursuant to law for the care and treatment of ill or injured persons or to the Covered Person's home country, when the Covered Person is critically ill or Injured,

and appropriate local care is not available, we will pay the actual charges incurred not to exceed $75,000 subject to the prior approval of the plan administrator for the Policy and the attending Physician. Payment of a benefit under the terms of this provision is in lieu of all benefits otherwise payable under the Policy and any Riders. Insurance for the Covered Person ends upon the evacuation.

REPATRIATION BENEFIT

Upon receipt of due proof of a Covered Person's death, we will pay the actual charges for the preparation and transportation of the body to his home country or country of regular domicile, subject to the approval of the plan administrator of the Policy. If applicable, such action will be in accordance with any international standards. The benefit payable is not to exceed $75,000 and death must occur at least 100 miles away from the Covered Person's city of residence. Benefits provided by this provision are paid in addition to any other benefits payable under the Policy.

EXCLUSIONS

Benefits will not be paid under this Policy and any attached Rider for any expenses which result from:

(1). Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth;

(2). Eyeglasses, radial keratotomy, contact lenses, or prescriptions or examinations except as required for repair caused by a covered Injury;

(3). Except as State mandates: Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within 24 hours of the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;

(4). Elective Surgery or Elective Treatment;

(5). Declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;

(6). Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law;

(7). Injury sustained or Sickness contracted while in the service of the armed forces of any country. When an Insured enters the armed forces, we will refund any unearned pro-rata premium with respect to such person;

(8). Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of other insurance;

(9). Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate sport, contest or competition sponsored by the school, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant;

(10). Taking of any drug, medication, narcotic or hallucinogen, unless as prescribed by a Physician, except as State mandates;
(11). Committing or attempting to commit an assault or felony; or fighting, except in self defense;
(12). Organ transplants;
(13). Elective abortion;
(14). Services and supplies not Medically Necessary for the diagnosis recommended by the attending Physician;
(15). Treatments, procedures, facilities, equipment, drugs, devices, supplies or services that are experimental or investigative, except as State mandates;
(16). Homemaking, companion or chronic (custodial) care services. Charges of a home health aide who is a member of your household. Charges of any care provided by relatives (by blood, marriage or adoption);
(17). Expenses resulting from a motor vehicle accident for which benefits are payable from other valid insurance;
(18). Abortion, unless the life of the mother would be endangered if the fetus would be carried to term;
(19). Tests which are not Medically Necessary for the diagnosis or treatment of your condition or which are not specifically ordered by the admitting Physician.

STUDENT ASSISTANCE SERVICES

(Administered by On Call International)

Nurse Helpline: On Call shall provide Students enrolled in this Plan with clinical assessment, education and general health information. This service shall be performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: Each Insured Student and his/her enrolled Dependents are eligible for travel assistance services when traveling 100 miles or more away from their home and campus address. Travel Services are only available for medical claims that are covered under the College's Student Accident and Sickness Insurance Plan. Services provided include: Emergency Medical Transportation (Evacuation/Repatriation); Medical Monitoring; Medical, Dental, & Pharmacy Referrals; Deposit, Advance, & Payment Guarantees; Dispatch of Medicine, Physician, or Nurse; Return of Deceased Remains; Return of Minor Children Assistance; Pre-Trip Information; 24/7 Emergency Travel Arrangements; Translation Assistance; Emergency Travel Funds Assistance; Worldwide Legal Assistance; Lost/Stolen Travel Documents Assistance; Emergency Message Forwarding; and Lost Luggage Assistance.

Identity Theft Recovery Assistance: In the event that a covered student suspects he or she is a victim of identity theft, the student may contact On Call International to speak to the Identity Theft Recovery Unit. The Identity Theft Recovery Unit is a team of trained Fraud

Specialists who will listen, document, and support participants who experience identity theft. The Fraud Specialist will: obtain participant's permission to pull and review their 3-bureau credit report in detail, with the participant; enroll the customer in six months of daily credit bureau monitoring to monitor and detect suspicious activity; document the event and contact history with participant; at participant request, assist in the placement of Fraud Alerts with major credit reporting agencies; write dispute letters on behalf of participant for signing and forwarding to National Credit Bureaus and Creditors. The Identity Theft Recovery Unit provides victims with a Fraud First Aid Kit which includes: Tips for Fraud Victims; Credit Bureau Reporting Agency Information; Contact History Tracking; Prepopulated letters to creditors to dispute suspicious items.

Bedside Visit: In the event that a covered student will be hospitalized 7 days or longer, On Call International will provide a benefit of up to $2,500 for a parent or family member to join the hospitalized student. The benefit can go towards transportation and accommodations. In all cases On Call International must make and pay for the travel and accommodations arrangements. There is no reimbursement for transportation or accommodations if made by the family or school.

Emergency Return Home: If a parent or sibling of a covered student dies or is hospitalized for a life threatening illness while the student is away at school (100 miles or more), On Call International will provide a benefit of up to $2,500 for the student to return home. In all cases On Call International must make and pay for the travel arrangements. There is no reimbursement for transportation if made by the student, family or school.

U.S. & Canada Toll Free: 866-525-1955 International Collect: 603-328-1955

Note: The On Call related services listed above are not insurance and are not connected with or provided by Monumental Life Insurance Company.

CLAIM PROCEDURE

In the event of a claim for an Injury or Sickness:

1. Complete a claim online or print a claim form at www.BollingerColleges.com/SIT. Notify the Claims Administrator within 30 days after the date of the covered Injury or commencement of the covered Sickness, or as soon as is reasonably possible.
2. Itemized billings must be submitted within ninety (90) days of treatment. The Covered Person's name and identification number need to be included.
3. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned, unless bill receipts and proof of payment are submitted.

All Claims and correspondence should be submitted to the Claims Administrator shown below:

Bollinger
Insurance Solutions

PO Box 727 • Short Hills, NJ 07078-0727
866-267-0092 (Claims/Coverage) 800-526-1379 (Other Questions)
www.BollingerColleges.com/SIT

Claims Administered by:

Bollinger
Insurance Solutions

PO Box 727
Short Hills, NJ 07078
866-267-0092 (Claims/Coverage)
800-526-1379 (Other Questions)
www.BollingerColleges.com/SIT

This brochure provides a description of your insurance program. You may obtain a complete certificate of insurance, including your appeal rights and grievances procedures, by accessing the link above.

Local Servicing Broker:
The Richards Group• 48 Harris Place
P.O. Box 820 • Brattleboro, VT 05302

Network Provider:

First Health Network
www.MyFirstHealth.com
800-226-5116

Underwritten by:
MONUMENTAL LIFE INSURANCE COMPANY
Cedar Rapids, Iowa
a Transamerica company

Representations of this plan
must be approved by the Company.

This is not the Policy. Rather it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the state in which it is issued. Any provisions of the Policy, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Policy# CVT413J
Policy Form SH5000GPM 26086878