Northwood University
(“the Policyholder”)

2015 – 2016
Student Health Insurance Plan
(“the Plan”)

Administrator Policy Number: CHH9026916
Underwriter Reference Number: CAS9148970

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-MI. Please read this brochure carefully as it contains specific information applicable to the Policy issued in your state. The Policy on file at the University contains all of the 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. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.
Coverage

Northwood University requires that all full-time students (12 or more credits), domestic and international, obtain and maintain health insurance coverage while enrolled at the University. Therefore, **all full-time students will be automatically enrolled in the Northwood University Student Health Insurance Plan (“the Plan”) and the cost for coverage will be charged on their tuition invoice unless coverage under the Plan is waived by submitting proof of coverage under another US healthcare plan by the waiver deadline. (See Waiver Procedure and Deadline page 3.)** The Plan covers Eligible Expenses incurred for a covered Injury or a Sickness as provided by the Policy.

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. An eligible student who experiences ineligibility under another creditable coverage and who wishes to enroll in the Plan, must email proof of ineligibility to qualifier@studentinsurance.com.

Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company’s only obligation is to refund premium less any claims paid.

Students covered under the Plan may enroll their eligible dependents. Eligible dependents include: (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. 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.

If a Covered Student wishes to enroll his or her eligible dependent(s), please contact the Wellness Center for assistance in their enrollment prior to the dependent enrollment deadline of **September 11, 2015.**
The Policy becomes effective at 12:01 a.m. on August 1, 2015, and terminates at 11:59 p.m. on July 31, 2016. The coverage of an eligible student, including the student who initially waived coverage and subsequently enrolls within 31 days of ineligibility under another creditable coverage, 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. A covered dependent’s coverage shall take effect on the later following dates: (1) the date the coverage for the Covered Student becomes effective; or (2) the date the dependent is enrolled for coverage, provided premium is paid when due.

Insurance for a Covered Student will end at 11:59 p.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 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).

If withdrawal from the Policyholder’s school is for other than the Covered Student’s entry into the armed services, 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.

Except as specifically provided in the Policy, dependent coverage expires concurrently with that of the Covered Student.

Benefits are payable only for those Eligible Expenses incurred while the Policy is in effect as to the Covered Person. Eligible Expenses incurred after the Covered Person’s termination of insurance are not covered except as provided in the Policy.

**EXTENSION OF BENEFITS**

If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital confinement. Such benefits will be payable until the earliest of: (1) the date the Hospital confinement ends; (2) the end of the 30 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

**WAIVER PROCEDURE AND DEADLINE**

Students that currently have coverage under another US healthcare plan may waive coverage under the Plan with proof of coverage under another US healthcare plan. Online waivers must be completed by the waiver deadline (see below). Otherwise, the student will be responsible for the insurance premium under the Plan.

To access the online waiver form:
2. Click on “Waiver Form”.
3. Complete the online form and submit the waiver.

Submitted waiver information will be verified with the student’s insurance company as part of the insurance verification process. If insurance status cannot be verified, the waiver will not be granted and the insurance premium will be charged to the student’s account.

**Fall Semester Waiver Deadline (annual enrollment): September 11, 2015**

**Spring Semester Waiver Deadline (for new students to the University in the Spring semester only): January 22, 2016**

No waivers will be accepted after the waiver deadline for the term. The insurance charge for the Plan will not be removed from the student’s tuition bill without an approved waiver.
# 2015-2016 STUDENT HEALTH INSURANCE PLAN PREMIUMS

<table>
<thead>
<tr>
<th></th>
<th>Fall/Annual Premium (8/1/15 – 7/31/16)</th>
<th>Spring Premium* (1/1/16 – 7/31/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only</td>
<td>$1,149</td>
<td>$672.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,873</td>
<td>$1,681</td>
</tr>
<tr>
<td>Each Child</td>
<td>$1,724</td>
<td>$1,009</td>
</tr>
</tbody>
</table>

*New students to the University in the Spring semester only

## CONTINUATION OF COVERAGE

If a Covered Student has lost eligibility under the Policy because he or she has graduated from the Policyholder, he or she has the right to exercise the option to continue coverage for up to 6 months beginning on the date coverage would otherwise terminate. When the Covered Student chooses to exercise this right, his or her written request, proof of graduation and the appropriate premium must be received by the Company within 31 days following the later of: (a) the date coverage under the Policy terminates; or (b) the date notice of the right of continuation is given by the Policyholder. In no event will the premium for the continued coverage be more than 2% higher than the premium charged prior to termination. In no event will this option to continue coverage be extended beyond the number of months initially requested. Continuation of coverage will be subject to the terms and conditions of the Policy in effect on the date the Covered student becomes eligible under this option.

## CERTIFICATE OF CREDITABLE COVERAGE

The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Policy is terminated. In addition, Certificates shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time. In order to obtain a Certificate of Creditable Coverage, please contact: AIG, PO Box 2407, Florence, SC 29503, visit our website at www.studentinsurance.com/Schools/MI/Northwood/ or call 1-888-722-1668

## MANDATED BENEFITS

This Plan also covers applicable Mandated Benefits as required by the State of Michigan. Please see the complete Policy on file with the Policyholder for full details.

## DEFINITIONS

“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.

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

“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 this Policyholder who is insured under the Policy.

“Doctor” 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.

“Eligible Expense” 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) with respect to the Preferred Provider, is the Allowable Charge; (d) is the negotiated rate, if any.; and (e) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the extension of benefits provision.
“Emergency Medical Condition” means the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the Covered Person’s health or to a pregnancy in the case of a pregnant Covered Person, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

“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.

“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; (c) as a place for custodial or educational care; or (d) as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term “Hospital” includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) 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:
(a) 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;

(b) 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;

(c) 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

(d) 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” 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. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

“Urgent Care Provider” means: (a) a freestanding medical facility which: (i) provides unscheduled medical services to treat an Urgent Condition; (ii) routinely provides ongoing unscheduled medical services for more than 8 consecutive hours; (iii) makes charges; (iv) is licensed and certified as required by any state or federal law or regulation; (v) keeps a medical record on each patient; (vi) provides an ongoing quality assurance program (this includes reviews by Doctors other than those who own or direct the facility); (vii) is run by a staff of Doctors, at least one of whom is on call at all times; (viii) has a full-time administrator who is a Doctor; or (b) a Doctor’s office. It is not the emergency room or outpatient department of a Hospital.

“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.

EXCESS PROVISION

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same Injury or Sickness, on a provision of service basis or on an expense incurred basis under any other valid and collectible insurance. If the other valid and collectible insurance provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose policy or service contract has been in effect for the longer period of time at the date of such Injury or Sickness.

For purposes of the Policy, a Covered Person’s entitlement to other valid and collectible insurance will be determined as if the Policy did not exist and will not depend on whether timely application for benefits from other valid and collectible insurance is made by or on behalf of the Covered Person.

Benefits under the Policy will be reduced to the extent that benefits for expenses are covered by any other valid and collectible insurance whether or not a claim is made for such benefits.

The Company will pay the Eligible Expenses incurred for Injury or Sickness up to the first $200 on a primary basis. Such Eligible Expenses will be payable in accordance with the terms of the Policy. Subsequent submissions of claims for Eligible Expenses for the same Injury or Sickness which are in excess of $200 will subject the balance of that submission of claim to the Excess Provision.
NON-DUPLICATION OF COVERAGE

If benefits are payable under more than one provision under the Policy, then benefits will be provided only under the provision providing the greater benefit.

NORTHWOOD UNIVERSITY SCHEDULE OF BENEFITS

This Plan pays Eligible Expenses at the applicable covered percentage after any applicable co-payments for a covered Injury and/or covered Sickness.

| Aggregate Maximum Benefit per Policy Year (all conditions combined) | Unlimited |
| Deductible per Policy Year per Covered Person | $250 |

Out of Pocket Maximum

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, charges in excess of a specified maximum or charges incurred for any services not covered under the Policy.

When this benefit 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 in 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, 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.

| Per Covered Person: $6,350 | Per Family: $12,700 |
| Per Covered Person: $6,350 | Per Family: $12,700 |

ELIGIBLE EXPENSES

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
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</thead>
</table>

INPATIENT BENEFITS

<p>| Daily Room and Board (except ICU, limited to the average semi-private room rate) | 80% of Allowable Charges | 60% of R&amp;C Charges |
| Hospital Miscellaneous 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) | 80% of Allowable Charges | 60% of R&amp;C Charges |
| Surgical Expense (when Injury or Sickness requires two or more surgical procedures performed through the same approach, and at the same time or immediate succession, the Company will pay for the most expensive procedure performed.) | 80% of Allowable Charges | 60% of R&amp;C Charge |
| Assistant Surgeon | 25% of amount payable for surgery | 25% of amount payable for surgery |
| Anesthesia | 80% of Allowable Charges | 60% of R&amp;C Charges |
| Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) | 80% of Allowable Charges | 60% of R&amp;C Charge |
| Doctor ’s Visits (other than a Doctor who performed surgery or administered anesthesia; limited to one visit per day and not related to | 80% of Allowable Charges | 60% of R&amp;C Charges |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Company Share</th>
<th>Plan Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Pre-Admission Testing (Hospital confinement must occur within 3 days of the testing)</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Mental and Nervous Disorders</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Alcoholism and Substance Abuse Expense</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Expense (when Injury or Sickness requires two or more surgical procedures performed through the same approach, and at the same time or immediate succession, the Company will pay for the most expensive procedure performed.)</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous (when scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding physiotherapy or take-home drugs and medicines)</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>25% of amount payable for surgery</td>
<td>25% of amount payable for surgery</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Doctor’s/Specialist’s Visits limited to one visit per day and does not apply when related to surgery or physiotherapy. Includes infusion therapy and benefit for nutritional counseling.</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Consultant’s Fees Expense</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Rehabilitative Care (physical therapy, occupational therapy, chiropractic, cardiac/pulmonary, speech and hearing therapy)</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery (for use of Hospital emergency room including operating room, laboratory and x-ray examinations, and supplies)</td>
<td>80% of Allowable Charges after a $150 co-pay per visit. Waived if Covered Person is admitted to Hospital</td>
<td>80% of R&amp;C Charges after a $150 co-pay per visit. Waived if Covered Person is admitted to Hospital</td>
</tr>
<tr>
<td>Urgent Care Expense</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Diagnostic Services and Medical Procedures performed by the Doctor (other than Doctor’s visits, physiotherapy, x-rays and lab procedures)</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Laboratory and X-Ray Examinations</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Paid the same as any other Sickness</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>CAT Scan/MRI/PET Scan</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>80% of Allowable Charges after a $10 co-pay per visit</td>
<td>60% of R&amp;C Charges after a $10 co-pay per visit</td>
</tr>
</tbody>
</table>
### Dialysis and Filtration Procedures
- 80% of Allowable Charges after a $10 co-pay per visit
- 60% of R&C Charges after a $10 co-pay per visit

### Intravenous Home Therapy
- 80% of Allowable Charges after a $10 co-pay per visit
- 60% of R&C Charges after a $10 co-pay per visit

### Mental and Nervous Disorders
- Paid the same as any other Sickness
- Paid the same as any other Sickness

### Alcoholism or Substance Abuse
- Paid the same as any other Sickness
- Paid the same as any other Sickness

### Prescribed Medicines Expense
Prescriptions must be filled at a Catamaran retail participating pharmacy – limited to 30-day supply. This benefit includes all prescribed FDA-approved birth control methods. Benefits will be paid at 100% and the co-pay will be waived for prescribed FDA-approved birth control.

<table>
<thead>
<tr>
<th></th>
<th>80% of R&amp;C Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 co-pay for generic drugs and $25 co-pay for brand name drugs. For the complete listing of providers, please go to <a href="http://www.studentinsurance.com/Schools/MI/Northwood/">www.studentinsurance.com/Schools/MI/Northwood</a></td>
</tr>
</tbody>
</table>

### Preventive Services as mandated by the Patient Protection and Affordable Care Act.
(To view a list of covered preventive services, log onto [www.hhs.gov/healthcare/prevention/index.html](http://www.hhs.gov/healthcare/prevention/index.html)).

- 100% of Allowable Charges, not subject to deductibles or co-pays
- 60% of R&C Charges

### Dental Treatment Expense
(for Covered Persons age 19 and older)

<table>
<thead>
<tr>
<th>Covered Percentage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Services</td>
</tr>
<tr>
<td>Basic Services</td>
</tr>
<tr>
<td>Primary/Major Services</td>
</tr>
</tbody>
</table>

- 100%
- 50%
- 50%

See the complete Policy on file with the University for full details.

### Pediatric Dental Treatment Expense
(for Covered Persons under age 19 only)

<table>
<thead>
<tr>
<th>Covered Percentage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
</tr>
<tr>
<td>Basic Services</td>
</tr>
<tr>
<td>Major Services</td>
</tr>
<tr>
<td>Oral Examination (Preventive)</td>
</tr>
<tr>
<td>X-Ray and Pathology</td>
</tr>
<tr>
<td>Prophylaxis and Fluoride Applications (Preventive)</td>
</tr>
<tr>
<td>Amalgam Restorations – Primary and Permanent Teeth</td>
</tr>
<tr>
<td>Composite Restorations</td>
</tr>
<tr>
<td>Oral Surgery (includes local anesthesia and routine post-operative care) Extractions</td>
</tr>
<tr>
<td>Endodontics (excluding final restoration)</td>
</tr>
<tr>
<td>Major Restorative (crowns, bridges partial and full dentures)</td>
</tr>
</tbody>
</table>

- 100%
- 50%
- 50%
- 50%
- 50%
- 50%
- 50%

See the complete Policy on file with the University for full details.
Pediatric Vision Care Expense
(for Covered Persons under age 19 only)

Co-pay Amount per Visit:
- Examination $25
- Materials $75

Covered Percentage: 100%

Standard Plastic Lenses

Maximum Amount:
- Single Vision $50
- Bifocal $50
- Trifocal $50
- Lenticular $50
- Progressive $50

Frames:
Contact Lenses (in lieu of eyeglass lenses and frames) $150

Fit, follow-up & materials:
- Effective: $150
- Medically Necessary: $150

See the complete Policy on file with the University for full details.

<table>
<thead>
<tr>
<th>OTHER SERVICES</th>
<th>80% of Eligible Expenses</th>
<th>80% of Eligible Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Expense</td>
<td>80% of Eligible Expenses</td>
<td>80% of Eligible Expenses</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Same as any other Sickness</td>
<td>Same as any other Sickness</td>
</tr>
<tr>
<td>Hospice Care Expense</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Home Health Care Expense</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment (no benefits will be payable for rental charges in excess of the purchase price)/Orthopedic Braces and Appliances (payable only upon a Doctor’s written prescription)/Prosthetic Appliances and Devices</td>
<td>80% of Allowable Charges</td>
<td>60% of R&amp;C Charges</td>
</tr>
<tr>
<td>Dental (Injury only)</td>
<td>80% of R&amp;C Charges, limited to $500 maximum per policy year</td>
<td></td>
</tr>
</tbody>
</table>

**REPATRIATION OF REMAINS/MEDICAL EVACUATION BENEFITS**

**Combined Maximum Limit of $50,000**

**REPATRIATION OF REMAINS BENEFIT:**
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 Policy limitations, 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 this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance. Please see page 13 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.
MEDICAL EVACUATION BENEFIT:

The Company will pay, subject to the Policy limitations, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Emergency Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all emergency Evacuations due to all Injuries from the same Accident or all emergency Sicknesses from the same or related causes. Travel Guard must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance. Please see page 13 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

PREFERRED PROVIDER ORGANIZATION

Preferred Provider Organization: Cofinity

Toll-Free Telephone Number: 800-226-5116

Cofinity Website: www.cofinity.net

Persons insured under this Plan may choose to be treated within or outside of the Cofinity PPO Network. Reimbursement rates will vary depending upon the source of card as described under the Schedule of Benefits herein. If a Covered Person seeks treatment from a non-PPO provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not guarantee that all providers at the Hospital are participating providers. In addition, if a Covered Person is referred by a participating provider to another facility or provider, it does not mean that the provider or facility to which the Covered Person is referred is also a participating provider. It is the Covered Person’s responsibility to verify that the provider is part of the PPO. A list of providers in the Cofinity Network is available for review via the “Preferred Provider Lookup” that can be accessed at www.studentinsurance.com/Schools/MI/Northwood/.

EXCLUSIONS

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 Services mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by the Policyholder’s Health Service, infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy; hearing aids, or prescriptions or examinations for such. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery. “Cosmetic surgery” shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and 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.
10. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins or anti-toxins except as specifically provided in the Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
11. as a result of committing or attempting to commit an assault or felony or participation in a riot or civil commotion.
12. after the date insurance terminates for a Covered Person except as may be specifically provided in the extension of benefits provision.
13. for any services rendered by a Covered Person’s immediate family member.
14. for any treatment, service or supply which is not Medically Necessary.
15. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
16. for surgery and/or treatment of: circumcision; deviated nasal septum, including submucuous resection and/or other surgical
correction thereof unless due to Injury occurring while coverage is in force; fertility tests; learning disabilities; non-malignant warts,
moles and lesions unless Medically Necessary; This exclusion does not apply to Preventive Services mandated by the Patient
Protection and Affordable Care Act.
17. for routine physical examinations, health examinations or preschool physical examinations, including routine care of a newborn
infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy. This exclusion does not apply to
Preventive Services mandated by the Patient Protection and Affordable Care Act.
18. for sterilization or sterilization reversal, including surgical procedures and devices except as specifically provided in the Policy; or
for birth control except as specifically provided in the Policy.
19. for elective sterilization or its reversal except as specifically provided, artificial insemination or in vitro fertilization.
20. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle; or bungee
jumping.
21. for Injury resulting from: hang gliding; parasailing; sky diving; flight in an ultra light aircraft; glider flying; sail planing; or parachuting.
22. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
23. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
24. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle; or bungee
jumping.
25. within the Covered Person’s home country of domicile with respect to an international Covered Person.
26. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

SUBROGATION

In the event any payments for benefits provided to a Covered Person are because of an Injury or Sickness caused by a Third Party’s
wrongful act or negligence, the Company, to the extent of that payment, will be subrogated to any recovery or right of recovery the
Covered Person has against that Third Party, provided: (a) the Covered Person is entitled to payment for Hospital, surgical or medical
services as the result of a Third Party settlement or court judgment; and (b) such settlement or judgment specified an amount or portion
of payment that represents payment for such benefits; and (c) the Company has paid benefits to the Covered Person under the Policy
for the same services or benefits covered by the settlement or judgment.

The Covered Person agrees to make a decision on pursuing a claim against a Third Party within 30 days of the date the Company
requires that the Covered Person provide notice of claim for the Injury or Sickness for which benefits under the Policy are sought and to
notify the Company of his or her decision within such 30 day period.

In the event the Covered Person decides not to pursue payment of claim against such Third Party, the Covered Person: (a) authorizes
the Company to pursue, sue, compromise or settle any such payment of claim in the name of the Covered Person; (b) authorizes the
Company to execute any and all documents necessary; and (c) agrees to cooperate fully with the Company in the prosecution of any
such payment of claim.

If the Company exercises its rights under this provision, it will recover no more than the amount paid under the Policy for such benefits.
The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim,
cause of action or right by or on behalf of a Covered Person against any Third Party or coverage.

"Subrogation" means the Company’s right to recover any benefit payments made under the plan: (a) because of an Injury or Sickness
to a Covered Person caused by a Third Party’s wrongful act or negligence; and (b) which become recoverable from the Third Party or
the Third party’s insurer.

The Company’s right of subrogation will not be enforced until the Covered Person has been made whole, as determined by a court of
law, as a result of Injury or Sickness.

"Third Party" means any person or organization other than the Company, the Policyholder or the Covered Person.
This provision will not apply if it is prohibited by law.
CLAIMS FILING ASSISTANCE

1. If at the University, report at once to the University Nurse or the Health Service.
2. If away from the University, secure treatment at the nearest Hospital, pay the bills and obtain a receipt for payment. Obtain instructions for claims filing from the Student Health Service and follow those instructions fully and promptly. It is the COVERED STUDENT’S responsibility to see that claim forms are completed fully and returned to the Student Health Service together with ITEMIZED BILLS.
3. The University will forward all Claim forms to:
   AIG, Higher Education Mail Center
   PO Box 26050
   Overland Park, KS 66225
   1-888-622-6001

4. Bills for which benefits are to be paid must be submitted to AIG, Higher Education Mail Center within 90 days of the date of treatment.

Questions regarding enrollment, benefits, periods of coverage and claims should be directed to:

AIG, Higher Education Mail Center
PO Box 26050
Overland Park, KS 66225
1-888-622-6001

TRAVEL GUARD SERVICES

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 non-medical 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 fulltime, on-site 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.
Travel Guard Description of Services

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

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

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

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage & 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

At AIG, we value the trust our customers have placed in us. That is why protecting the privacy of personal information is of paramount importance to us. For more information please go to our website at www.studentinsurance.com

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