South Carolina State University
("the Policyholder")

2013 - 2014

**Student Health Insurance Plan**
(the “Plan”)

Customer Service
Questions: 1-888-722-1668
Email: scsu@studentinsurance.com
To waive / enroll: www.studentinsurance.com

www.studentinsurance.com

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

Administrator Policy # CHH0080274
Underwriter Reference # CAS9497108
Health care reform law notice

Your student health insurance coverage, offered by National Union Fire Insurance Company of Pittsburgh, Pa., 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 $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: $500,000 on Essential Health Benefits. If you have any questions or concerns about this notice, contact AIG, Educational Markets, at 1-888-722-1668. 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.

ELIGIBILITY

All Undergraduate Students taking 6 or more credit hours and Graduate or Professional Students enrolled in at least 6 or more credit hours of graduate level courses will be automatically enrolled in the Plan and the premium for the insurance will be billed to student’s account unless proof of comparable coverage is furnished by the waiver deadline.

Waivers will only be accepted online at www.studentinsurance.com, and no waivers will be accepted after the waiver deadline date. The waiver deadline date for submitting a waiver for Fall 2013 is September 30, 2013. The waiver deadline date for submitting a waiver for Spring/Summer 2014 is January 31, 2014. 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 must actively attend classes at the University for at least 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. Home study, correspondence, Internet and television (TV) courses do not fulfill the eligibility requirements that the student actively attended classes. 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 Plan eligibility requirements have been met. If it is discovered that the Plan eligibility requirements have not been met, the Company’s only obligation is to refund premium less any claims paid.
EFFECTIVE AND TERMINATION DATES
The Policy on file at the University becomes effective 12:01 a.m. on August 1, 2013 and terminates 11:59 p.m. July 31, 2014. The coverage of an eligible student who enrolls for coverage under the Plan shall take effect at 12:01 a.m. on the latest of the following dates: (1) the Plan 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 University’s coverage term 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 University.

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur: (a) the date the Plan terminates; (b) the last day for which any required premium has been paid; or (c) the date on which the Covered Student withdraws from the school because of: (1) entering the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made.); or (2) withdrawal from school during the first 30 days of the period for which enrollment was made.

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

COORDINATION OF BENEFITS PROVISION
The Company will coordinate benefits with other health insurance carriers when duplicate coverage exists. Total payment from this coverage and other health insurance coverages under which the Covered Person is enrolled shall not exceed 100% of the Eligible Expenses.

CERTIFICATE OF CREDITABLE COVERAGE
Coverage under this Plan is "creditable coverage" under Federal law. When coverage terminates, the Covered Person can request a Certificate of Creditable Coverage which is evidence of his or her coverage under this Plan. The Covered Person may need such a certificate if he or she becomes covered under a group health plan or other health plan within 63 days after coverage under this Plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions the Covered Person had before enrolling, then this Certificate of Creditable Coverage may be used to reduce or eliminate those exclusions or limitations. In order to obtain a Certificate of Creditable Coverage please contact AIG, Educational Markets, at 1-888-722-1668. Your Certificate of Coverage will be placed in your online account when you call.

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 continuous Hospital confinement ends; (2) the end of a 90 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.
If a Covered Person is undergoing outpatient treatment for an Emergency Medical Condition on the termination date, Eligible Expenses shall include charges incurred for that Emergency Medical Condition, but only while they are incurred during the 30 day period following such termination of insurance, subject to the applicable Maximum Amounts of the Plan. The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Plan or any other health insurance policy in the ensuing term of coverage.

2013-2014 STUDENT HEALTH INSURANCE PLAN PREMIUMS

<table>
<thead>
<tr>
<th>PLAN PREMIUMS*</th>
<th>Fall</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$548.00</td>
<td>$767.00</td>
</tr>
</tbody>
</table>

*The Student Health Insurance Plan Premiums include an additional administrative fee.
To receive benefits under the Plan, Covered Students must visit Brooks Health Center first for treatment/referral. Exceptions are listed under “Referrals”.

This Plan also covers applicable Mandated Benefits as required by the State of South Carolina. Please see the Policy on file with the University for details.
<table>
<thead>
<tr>
<th>OUTpatient</th>
<th>Health Care at Brooks Health Center</th>
<th>Health Care In-Network</th>
<th>Health Care Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C</td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $300 copay per surgery</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C</td>
</tr>
<tr>
<td>Urgent Care Expense</td>
<td>$75 Copay per visit</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C</td>
</tr>
<tr>
<td>Hospital Emergency Room Expense</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>80% R&amp;C after a $350 copay per visit</td>
</tr>
<tr>
<td>Doctor’s Visits – benefits are limited to one visit per day</td>
<td>Covered under the Student Health Fee</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $35 copay per visit</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $35 copay per visit</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C</td>
</tr>
<tr>
<td>Laboratory and X-ray Examinations</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $35 copay per visit</td>
</tr>
<tr>
<td>Diagnostic Services and Medical Procedures performed by a Doctor (other than Doctor’s visits, physiotherapy, x-rays and lab procedures), including sickle cell anemia testing. (Not otherwise covered under Preventive Services).</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $35 copay per visit</td>
</tr>
<tr>
<td>Psychiatric Conditions</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $35 copay per visit</td>
</tr>
<tr>
<td>Prescribed Medicine Expense</td>
<td>Not Applicable</td>
<td>informedRx, Catamaran Corporation, participating pharmacies: 80% R&amp;C after a $100 Prescribed Medicines deductible per Policy Year and subject to the following copays per prescription or refill – limited to a 30 day supply: Generic: $20; Formulary Brand Name: $40; Non-Formulary and Specialty Brand Name: $100. Prescription Medicines Expense benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person’s Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic. This benefit applies to all prescribed FDA-approved birth control methods. The copay will be waived for prescribed FDA-approved birth control.</td>
<td>informingRx, Catamaran Corporation, participating pharmacies: 80% R&amp;C after a $100 Prescribed Medicines deductible per Policy Year and subject to the following copays per prescription or refill – limited to a 30 day supply: Generic: $20; Formulary Brand Name: $40; Non-Formulary and Specialty Brand Name: $100. Prescription Medicines Expense benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person’s Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic. This benefit applies to all prescribed FDA-approved birth control methods. The copay will be waived for prescribed FDA-approved birth control.</td>
</tr>
<tr>
<td>Consultant</td>
<td>Not Applicable</td>
<td>80% Allowable Charge</td>
<td>70% R&amp;C after a $35 copay per visit</td>
</tr>
</tbody>
</table>

Consultant
Not Applicable
80% Allowable Charge after a $20 copay per visit
70% R&C after a $35 copay per visit
SOUTH CAROLINA STATE UNIVERSITY PLAN SCHEDULE OF BENEFITS

OUTPATIENT CONTINUED

| Preventive Services: Please go to www.studentinsurance.com to view a list of Preventive Services (as specified by the Patient Protection and Affordable Care Act (PPACA)).  
  • For eligible Preventive Services rendered at the Brooks Health Center, Eligible Expenses will be paid at 100% Allowable Charge, not subject to deductibles or copays.  
  • If the Brooks Health Center offers a Preventive Service, and services are rendered outside the Brooks Health Center, Eligible Expenses will be paid at 80% Allowable Charge In-Network or 70% R&C Out-of-Network, whichever is applicable, subject to deductibles and copays.  
  • If the Brooks Health Center does not offer a Preventive Service, and services are rendered outside the Brooks Health Center, benefits will be paid at 100% Allowable Charge In-Network, not subject to deductibles or copays or 70% R&C Out-of-Network, subject to deductibles and copays.
| Ambulance (air or ground transportation): For use of a professional ambulance in an emergency: 80% R&C

ADDITIONAL INSURANCE PLAN BENEFITS

Maternity and Complications of Pregnancy: Paid the same as any other Sickness.

Alcoholism and Substance Abuse Expense: Paid the same as any other Sickness.

Suicide, Attempted Suicide and Intentionally Inflicted Injury: Medically necessary inpatient and outpatient services to treat medical emergencies resulting from such actions will be covered as an Emergency Medical Condition. (Medical Evacuation benefits resulting from attempted suicide or intentionally inflicted Injury will be considered under the Medical Evacuation benefit. Definitive treatment of any underlying mental health causal factors shall be covered under the mental and nervous disorders benefits.

Durable Medical Equipment and Orthopedic Appliance; orthopedic Braces and Appliances: 100% Allowable Charge at the Brooks Health Center/80% Allowable Charge In-Network/70% R&C Out-of-Network

Medical Evacuation and Repatriation of Remains: $1,000,000 combined maximum benefit (See Policy on file with the University for details).

DENTAL TREATMENT BENEFITS

Dental Treatment: Basic Dental Services: 80% R&C for cavities involving 1 surface (amalgam restorations - permanent teeth only) up to a maximum of $35 per surface per Policy Year.

Dental Treatment: Preventive Dental Services: $20 copay per visit; then 100% R&C for oral exam (limited to 2 per Policy Year), cleaning (limited to 1 per 6 month period), and bitewing x-ray (limited to 1 per Policy Year).

Dental Treatment: Removal of impacted wisdom teeth: $20 copay per Sickness; then 80% R&C up to a maximum of $1,000 per Policy Year.

Dental Treatment: Injury to sound natural teeth: $20 copay per Injury; then 80% R&C up to a maximum of $1,000 per Policy Year.

PLAN EXCLUSIONS and LIMITATIONS

The Plan does not cover nor provide benefits for loss or expenses incurred:
1. as a result of dental treatment, or dental x-rays except as provided elsewhere in this Plan. 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 this Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by this Policyholder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such; hearing aids; or treatment for visual defects and problems. “Visual defects” means any physical defect of the eye which does or can impair normal vision apart from the disease process. Vision examinations not related to prescription or fitting of lenses will be covered only when performed in connection with the diagnosis or treatment of Sickness or Injury. Eye refraction is not covered. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing apart from the disease process.
5. 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.
South Carolina State University Student Health Insurance Plan 2013-2014

PLAN EXCLUSIONS and LIMITATIONS continued...

6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
8. 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.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. 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. It also shall not include breast reconstructive surgery after a mastectomy.
11. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
12. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins or anti-toxins except as specifically provided in this Plan. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
13. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, illegal occupation, insurrection or civil commotion.
14. for Elective Treatment or elective surgery.
15. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
16. for any services rendered by a Covered Person’s immediate family member.
17. for any treatment, service or supply which is not Medically Necessary.
18. for loss due to voluntary use of any drug, narcotic or controlled substance, unless prescribed by a Doctor.
19. for or in relation to orthopedic shoes or devices intended to be placed inside shoes or other footwear.
20. for surgery and/or treatment of: acne except prescriptions for treatment of complications; allergy, including allergy testing and anti-toxins except prescription medications and injections; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof except for purulent sinusitis or unless due to Injury occurring while coverage is in force; infertility(male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; learning disabilities; Attention Deficit Disorder; nonmalignant warts, moles and lesions unless Medically Necessary; sleep disorders, including testing thereof; and alopecia. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
21. for routine physical examinations, health examinations or preschool physical examinations. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
22. for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purposes of removing nerve interference as a result of or related to distortion, misalignment or subluxation of or in the vertebral column except as specifically provided.
23. for patient controlled analgesia (PCA).
24. by a Covered Person who is not a United States Citizen for services performed within the Covered Person’s home country if the Covered Person’s home country provides national health insurance.
25. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle; or bungee jumping.
26. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate sports activity, including travel to and from the activity and practice; hang gliding; parasailing; sky diving; or sail planning.
27. for rest cures or custodial care.
28. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
29. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
30. for home health care.

PRE-EXISTING CONDITIONS LIMITATION
Pre-existing Conditions are not covered for the first 12 months following a Covered Person’s effective date of coverage under this Plan. This limitation will not apply if:
(a) the Covered Person has been covered under the University’s prior Plan for more than 12 consecutive months
immediately preceding the effective date of coverage under this Plan; or (b) the individual seeking coverage under this Plan has an aggregate of 18 months of creditable coverage and becomes eligible and applies for coverage under this Plan within 63 days of termination of prior creditable coverage; and (1) the individual’s most recent prior creditable coverage was under an employer group plan; and (2) the individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her; and (3) the individual is not eligible for coverage under any other group health plan, Medicare or Medicaid; and (4) the individual does not have other health insurance. The Pre-existing Conditions limitation does not apply to a Covered Person under age nineteen (19).

**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 this Plan is in effect.

**Covered Student** means a student of this Policyholder who is insured under this Plan.

**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.

**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: vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; and botox injections.

**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 Plan 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 a Sickness or Injury for which immediate 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; (c) a body organ or part would be seriously damaged; (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 in the definition of Emergency Medical Condition.

**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; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for mental or nervous disorders. The term "Hospital" includes: (a) a substance abuse treatment facility during any period in which it
PLAN DEFINITIONS CONTINUED...

provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; and (c) 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 Services for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

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

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

Reasonable and Customary (“R&C”) means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. “Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

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

PPO PROVIDERS

For services rendered in the State of South Carolina, Covered Persons insured under this Plan may choose to be treated within or outside of the Medcost PPO Network. For services rendered outside of the State of South Carolina, Covered Persons insured under this Plan may choose to be treated within or outside of the First Health PPO Network. Reimbursement rates will vary according to the source of care as described under the Plan Schedule of Benefits. Assignment of a Network Provider does not guarantee eligibility or right to student health benefits. For treatment or care received at a non-PPO provider because a PPO provider is not available, benefits for Eligible Expenses are payable at the PPO level. 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. To locate a PPO Provider please call 1-888-722-1668 or visit www.studentinsurance.com.
CLAIMS PROCEDURES
Please call 1-888-722-1668 for pre-notification of all Hospital confinements and day surgery prior to admission.

1. Written notice of claim must be given to the Company within 50 days after the occurrence or commencement of any loss covered by this Plan, or as soon thereafter as is reasonably possible. To submit the written claim form go to www.studentinsurance.com, log into your account and click on ‘student options’. The claim form can be submitted online electronically.
2. In the event that a PPO Provider submits the Covered Person’s claim(s), please be sure that the Provider photocopies the Covered Person’s insurance card.
3. The Covered Person should retain one copy of all claims information submitted for his or her records. PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (Hospital, Doctor and others), UNLESS A PAID RECEIPT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

PRE-NOTIFICATION RECOMMENDED
The Covered Person should report to the Company all non-emergency inpatient admissions to a Hospital, including length of stay, and all surgical procedures performed in an outpatient facility or ambulatory surgical center that require general anesthesia. To report an inpatient or outpatient service call 1-888-722-1668. Pre-Notification is not a guarantee that benefits will be paid.

REFERRALS
A referral from the Brooks Health Center is required before benefits under the Plan are payable. This provision does not apply if: (a) the Brooks Health Center is closed; (b) covered service is rendered at another facility during school breaks or vacation times; (c) medical care is received when student is more than 30 miles from campus; (d) medical care is obtained by a student who is not eligible to use the Brooks Health Center; (e) for maternity; (f) for mental disorders; or (g) for an Emergency Medical Condition; however, the student must return to the Brooks Health Center for necessary follow-up care. Benefits for Eligible Expenses incurred for medical care or treatment rendered for which a referral is required but not obtained will be excluded from coverage.

No authorization or referral requirement shall apply to obstetrical or gynecological care provided by in-network providers.

The applicable deductibles, coinsurance and copay amounts shall apply to all of the exceptions to the referral requirement shown above.

SUBROGATION
The Company shall be subrogated to all rights of recovery which any Covered Person has against any person, firm, or company to the extent of payments for benefits made by the Company to or for benefit of a Covered Person. The Covered Person shall provide and do whatever is necessary to secure all rights to the Company. If the South Carolina Director of Insurance, upon petition by the Covered Person, determines that the exercise of subrogation by the Company is inequitable and commits an injustice to the Covered Person, subrogation under this provision will not be allowed. This determination by the South Carolina Director of Insurance or his designee may be appealed to the Administrative Law Judge Division, as provided by law in accordance with §38-71-190.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
Maximum Amount: $10,000

The Company will pay the benefit below for Injuries to a Covered Person: (a) caused by an Accident which happens while covered by this Plan; and (b) which directly, and from no other cause, result in any of the losses listed below within 180 days of the Accident that caused the Injury.

For Loss of

<table>
<thead>
<tr>
<th>Maximum Amount</th>
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</thead>
<tbody>
<tr>
<td>Life</td>
</tr>
<tr>
<td>Both Hands or Both Feet</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
</tr>
<tr>
<td>One Hand and the Sight of One Eye</td>
</tr>
<tr>
<td>One Foot and the Sight of One Eye</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
</tr>
<tr>
<td>The Sight of One Eye</td>
</tr>
<tr>
<td>Thumb and Index Finger of Same Hand</td>
</tr>
</tbody>
</table>

"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 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.

If a Covered Person suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.

STUDENT ACCIDENT INSURANCE PLAN INTERCOLLEGIATE SPORTS ACCIDENT COVERAGE
Insurance Underwritten by National Union Fire Insurance Company of Pittsburgh, Pa.; Policy#EMH0001564/CAS9497109
All students enrolled in the South Carolina State University Student Insurance Plan will be automatically enrolled in a separate Accident Insurance Policy underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. Full details of the coverage are contained in the Policy on file with South Carolina State University.
Procedures on How to Access Travel Guard and Student Assist Services 24-Hour Assistance Call Services  
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.  
  • Ask the international operator to connect to an AT&T operator.  
  • Request the AT&T 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 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 your TPA is AIG Property Casualty Claims, Inc., in South Carolina.  
• Provide your Policy Number or School Name  
• Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.  

**DESCRIPTION OF SERVICES**  
General Information: Services listed below include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency, exchange rates, local Bank/Government holidays, and by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.  
• Visa & Immunization  
• Weather & Exchange Rates  

**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  
• Lost/Stolen Luggage Information  
• Claims-related Assistance & Personal Effects Assistance  
• Lost Document Assistance & Cash Transfer Assistance  
• Embassy/Consulate  
• Telephone Interpretation  
• Enroute Travel Assistance  

**Medical:** These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard’s Medical Staff in addition to other network providers and often include postcase 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:**  
• Evacuation  
• Repatriation of Remains  

**REPATRIATION OF REMAINS AND MEDICAL EVACUATION**  
(Benefits for Repatriation of Remains and Medical Evacuation are provided by National Union Fire Insurance Company of Pittsburgh, Pa.)  

**COMBINED MAXIMUM LIMIT OF $1,000,000**  

**REPATRIATION OF REMAINS**  
In the event an Injury or emergency Sickness causes your death while you are outside your home country, the plan will reimburse Eligible Expenses reasonably incurred for preparation and transportation of the body remains.  

**MEDICAL EVACUATION**  
The plan will pay for evacuation to the nearest adequate medical facility following a covered Injury or emergency Sickness if you are outside your home country and a Doctor determines that adequate medical treatment is not locally available. (Benefits will be considered only after being hospitalized for a least 5 consecutive days.)  

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

**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 visit www.studentinsurance.com and log into your secure online account. For more details visit the AIG Property Casualty Claims, Inc., website at www.studentinsurance.com.
An image of a page from the South Carolina State University Student Health Insurance Plan 2013-2014 brochure, including information about the plans available, the coverage provided, and ways to access online services. The page emphasizes the importance of maintaining coverage continuity and the availability of online tools for policyholders. It also mentions that similar coverage may be purchased for the following academic year. The brochure provides contact information for claims and online services, along with a note about the policy being non-renewable and one-year term insurance. The document also highlights important information for policyholders, emphasizing the need to review the policy's provisions, exclusions, limitations, definitions, and qualifications. The brochure is designed to assist students in understanding their health insurance coverage and how to access necessary services online.