STUDENT SICKNESS BENEFITS PLAN

Plan Number: SFP26-WTS

for Students of:

WESLEY THEOLOGICAL SEMINARY

For more information, go to:

www.eiia.org

Click on “For Students” and search for your institution.

Plan Administrator:

EIIA

IMPORTANT INFORMATION

PLEASE READ THIS PLAN AND ACCOMPANYING CERTIFICATE & SUMMARY OF BENEFITS (CSB) CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section followed by a review of the CSB schedule. The meaning of the Fdefined terms will help you understand the provisions of this Plan.

The educational institution shown on the cover of this Plan (the "Sponsor") has established this benefit plan to provide financial help for you when a covered loss occurs. The intent of this Plan is to supplement any Other Plan of benefits you are eligible to receive. This Plan provides benefits that offset deductible, co-pay and co-insurance obligations from the Other Plans that would otherwise deter you from seeking Medically Necessary Care.

The Sponsor is responsible for funding the payment of benefits of this Plan. The Sponsor has delegated the general responsibility for the administration of the Plan to the Plan Administrator. The Plan Administrator, in turn, has delegated claims administration and certain other duties to NAHGA, Inc. (the "Claims Administrator"). While one of the functions of Claims Administrator is to process claims according to Plan provisions, the final decision on any disputed claim may involve review of these files by the Plan Administrator. Benefits under this Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

As a covered Student of the Plan, your rights and benefits are determined by the provisions of this Plan document and the accompanying CSB. This Plan document also outlines what you must do to be covered and explains how to file claims.

The Sponsor has reserved the right to change or terminate the Plan at any time.

The Sponsor may from time to time enter into agreements, directly or indirectly, with health care providers or other third parties that would require the payment of benefits or the processing of claims and appeals in a manner other than as set forth in the Plan. To the extent of any such inconsistency, the Plan shall be deemed to be amended to conform to the requirements of those agreements.

Claims administered by:

NAHGA Claim Services
P.O. Box 189
Attn: Claims Dept.
Bridgton, ME 04009-0189

Phone: (877) 497-4980
Fax: (207) 647-4569
Email: eiia@nahga.com

TABLE OF CONTENTS

ELIGIBILITY 1
- Eligibility Classifications 1
- When Coverage Begins 1
- When Coverage Terminates 1

DESCRIPTION OF BENEFITS 2
- Benefit Qualification 2
- Benefits Payable 2
- Payment Conditions 2

DEFINITIONS 3

COVERED CHARGES 8

EXCLUSIONS 9

COORDINATION WITH OTHER PLAN BENEFITS 11
- Intent 11
- Exchange of Information 11
- Right of Recovery 11

SUBROGATION AND REIMBURSEMENT 12
- Applicability 12
- Right of Recovery 12
- Transfer of Rights 12
- Student Obligations 12

CLAIM PROCEDURES 13
- Claim Reporting Form 13
- Claim Procedures 13
- Payment, Denial, and Review 13
- Binding Arbitration 14
- Facility of Payment 14
- Time Limits 15
- Right of Recovery 15

PLAN ADMINISTRATION 16
- Allocation of Authority 16
- Powers and Duties of Plan Administrator 16
- Delegation by the Plan Administrator 16
- Fiduciary Liability 17

GENERAL PROVISIONS 17
- Terms of Coverage 17
- Benefits Not Transferable 17
- Application of ERISA and Other Laws 17
- Plan Funding 17
- Effect of Plan 17
- Waiver and Estoppel 18

Severability 18
Headings 18
Notices 18

ELIGIBILITY

To be eligible for benefits you must be a Student as defined under the Eligibility Classification in the CSB.

Eligibility Classifications

Class 1	Full-time undergraduate students
Class 2	Full-time undergraduate resident students
Class 3	Full-time and part-time undergraduate students
Class 4	Full-time undergraduate and graduate students
Class 5	All students
Class 6	Other as stated in the CSB.

When Coverage Begins

Your coverage becomes effective on the later of:

- the first day you are required to be at the Sponsor as a Student; or
- the first day of the Coverage Period as specified in the CSB.

When Coverage Terminates

- If the Plan terminates, your coverage ends at the same time. This Plan may be canceled or changed at any time without notice. If the Plan terminates or changes, you will remain covered for claims incurred but not filed or paid prior to Plan termination or change.
- If the Plan no longer provides coverage for the class of students to which you belong, your coverage ends on the effective date of that change.
- If you graduate from the Sponsor.
- If you withdraw or are dismissed from the Sponsor, whether or not coverage will be continued after the date of the withdrawal or dismissal will be determined by the Sponsor.
- Participation in the Plan may be terminated for the reasons listed below:
  - You knowingly give the Claims Administrator incorrect or incomplete information or fail to notify the Plan Administrator of changes in your status that may affect eligibility for benefits;
  - You knowingly misrepresent Plan enrollment status or coverage; or
  - You knowingly present an invalid prescription.
- Coverage terminates when the Coverage Period ends.

DESCRIPTION OF BENEFITS

Benefit Qualification

To qualify for payment of the benefits provided by your Plan you must:

- be a Student on the date medical Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations;
- the terms and conditions of COORDINATION WITH OTHER PLAN BENEFITS and SUBROGATION AND REIMBURSEMENT; and
- any applicable Deductible, Copayment, and Student Responsibility provisions set forth in the CSB.

Payment Conditions

If you have a medical condition resulting from a Sickness, the Plan will pay Medical Expense Benefits for Covered Charges as described in the CSB:

- in excess of any other available benefits or coverage;
- in excess of any Copayment amounts;
- at the payment percentage(s) indicated; and
- to the applicable limits (Maximum Sickness Limit, Outpatient Sickness Benefit Limit, Outpatient Mental Health and Substance Abuse Limit, Outpatient Surgical Benefit Limit, Emergency Room Benefit Limit, Dental Benefit Limit and Wellness Benefit Limit) set forth in the CSB.

In no event, however, will the total Medical Expense Benefits paid to you during any Coverage Period exceed the Coverage Period Maximum specified in the CSB.

DEFINITIONS

Several words and phrases are used to describe the Plan whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility;
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care;
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology;
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period;
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and staff members being aware of such procedures.

Certificate and Summary of Benefits (CSB) means the Certificate and Summary of Benefits that along with the Plan describes the benefits being provided by the Plan.

Claims Administrator means any entity authorized to process claims for benefits under this Plan.

Copayment; Copay means a specified dollar amount set forth in the CSB that you are required to pay each time certain or specified services are rendered.

Cosmetic Treatment and Services means Treatment or Service to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service is performed primarily for psychological purposes or is not Medically Necessary to correct or improve a bodily function. Cosmetic Treatment and Services include, but are not limited to, surgery, pharmacological regimens, and all related charges.

Coverage Period means the period (not to exceed 12 months) specified in the CSB.

Coverage Period Maximum means the maximum amount of Medical Expense Benefits that can be paid to you for claims incurred during any Coverage Period. The Coverage Period Maximum is specified in the CSB.

Covered Charges mean expenses:

- incurred by you as a result of Sickness for which you are legally obligated to pay;
- not in excess of the Usual, Reasonable and Customary charge;
- not in excess of the Maximum Benefit amount payable per service as shown in the CSB
- made for medical services, prescriptions and supplies not excluded under this Plan;
- made for services and supplies which are Medically Necessary; and
- made for medical Treatment and Services specifically included in the CSB.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges set forth in the CSB that must be incurred by you before benefits will be payable under this Plan for all or part of the remaining Covered Charges during the Coverage Period.

Dental Benefit Limit means the overall maximum of benefits payable for Dental Services per Coverage Period as listed on the CSB.

Dental Services means any Treatment or Service, provided to replace or restore any Natural Teeth.

Emergency Room Benefit Limit means the overall maximum of benefits payable for Covered Charges under this Plan per Sickness for a Medical Emergency as listed on the CSB.

Experimental or Investigational Measure means a drug, device, medical treatment, new technology, procedure, or supply, which is not recognized as a Covered Expense as follows:

- The drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment, new technology, procedure, or supply is furnished.
- The drug, device, medical treatment, new technology, procedure, or supply, or the patient's informed consent utilized with the drug, device, treatment, new technology, procedure, or supply, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval.
- Reliable evidence shows that the drug, device, medical treatment, new technology, procedure, or supply is the subject of on-going Phase I or Phase II clinical trials; is the research, Experimental study, or Investigational arm of on-going Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure, or supply is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply; or the written informed consent used by the

treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply.

Generally Accepted means that the Treatment or Service for the particular Sickness which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature;
- is in general use in the relevant medical or dental community; and
- is not under scientific testing or research.

Hospital means an institution that is:

- operated according to the laws pertaining to hospitals;
- primarily and continuously engaged in providing inpatient care and treatment through medical, diagnostic, and major surgical facilities, either on its premises or in facilities available to the hospital on a prearranged basis, under the supervision of a staff of doctors and with a 24-hour nursing service; and
- licensed as a hospital by the proper authority of the state in which it is located (if licensing is required by that state);

but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility or training center.

Hospital shall also include an Inpatient Alcohol or Drug Abuse Treatment Facility.

Hospital Confined; Hospital Confinement means a period of Treatment or Service while in a hospital, in excess of 18 consecutive hours, for treatment of a Sickness.

Hospital Confinement Charges mean Covered Charges by a Hospital for room, board, and other usual services, and by a Physician for pathology, radiology, or the administration of anesthesia while a person is Hospital Confined.

Hospital Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Immediate Family means your spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

Inpatient Alcohol or Drug Abuse Treatment Facility means an institution that:

- is licensed by the proper authority of the state in which it is located;
- is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services;
- is supervised on a full-time basis by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (RN).

Laboratory Services means Covered Charges for testing of materials, fluids, or tissues obtained from patients for the purpose of screening or diagnosing a condition and for determining appropriate treatment.

Maximum Sickness Limit means the overall maximum of benefits payable for Covered Charges under this Plan per Sickness as listed on the CSB.

Medical Emergency means a condition that requires treatment without delay and is evidenced by sudden and unexpected symptoms of a Sickness; and either is, or reasonably appears to be, life threatening; or would reasonably appear to preclude a complete recovery if not treated without delay.

Medical Expense Benefits means the Medically Necessary Care reimbursable under the Plan for Covered Charges incurred by eligible Students.

Medically Necessary or **Medical Necessity Care** means any Treatment or Service for a Sickness that is:

- prescribed by a Physician and required for the diagnosis or treatment of a Sickness;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by the Claims Administrator to be Generally Accepted.

The fact that a Physician may prescribe, order, recommend or approve a Treatment or Service does not, of itself, make the Treatment or Service Medically Necessary.

Mental Health and Substance Abuse means a mental or nervous disorder, alcoholism, or drug abuse requiring Treatment or Service by a Physician.

Natural Teeth means natural teeth or teeth where the major portion of the individual tooth is present, regardless of fillings or caps, and is not carious, abscessed, or defective.

Other Plan means any medical expense benefits provided under:

- any insured or non-insured group, service, prepayment, or other program arranged through an employer, trustee, union, or association;
- any program required or established by state or federal law (including Medicare Parts A and B);
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts;

Outpatient Mental Health and Substance Abuse Limit means the overall maximum of benefits payable for Covered Charges under this Plan per Sickness for outpatient Mental Health and Substance Abuse Treatment or Services as listed on the CSB.

Outpatient Sickness Benefit Limit means the overall maximum of benefits payable for Covered Charges under this Plan per Sickness as listed on the CSB.

Outpatient Surgical Benefit Limit means the overall maximum of benefits payable for Covered Charges under this Plan per Sickness for outpatient surgical treatment or service as listed on the CSB.

Physician means Doctor of Medicine (MD); Doctor of Osteopathy (DO); Acupuncturist, Audiologist; Certified Registered Nurse Anesthetist (CRNA); Chiropractor; Dentist; Certified Midwife; Occupational Therapist; Ophthalmologist; Physical Therapist; Physician's Assistant; Podiatrist (DPM); Psychiatrist, Psychologist; Registered Nurse (RN); Social Worker; and Speech Pathologist working within the scope of their license. Physician does not include you, your spouse, dependent, parent, brother or sister.

Physician Visit means a face-to-face meeting between a Physician or Physician's staff and a patient for the purpose of medical Treatment or Service.

Plan means the plan of medical expense benefits described in this booklet.

Plan Administrator means Educational & Institutional Insurance Administrators, Inc., an Illinois not-for-profit corporation or any successor designated by the Plan Sponsor.

Sickness means illness or disease of a Student. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of an illness or disease will be considered one Sickness.

Sponsor means the educational institution as listed on the CSB and the cover of this Plan .

Student means any person described under the Eligibility Classification in the CSB, or who meets the guidelines defined by the Sponsor and on file with the Administrator.

Student Responsibility means the percentage amount set forth in the CSB of Covered Charges for which you are responsible for any medical service or supply.

Student Health Clinic means a clinic or a medical service provider identified by your Sponsor who is delivering medical services under the direction and supervision of a Physician. Direction and supervision means the Physician co-signs any progress notes written by the Student Health Clinic; or there is a legal agreement that places overall responsibility for the Student Health Clinic's services on the Physician. To the extent provided in the CSB, you must obtain a referral from your Student Health Clinic before any Treatment or Service is rendered in order for that Treatment or Service to be covered under this Plan. The referral requirement does not apply to a Medical Emergency, to Mental Health and Substance Abuse, or when the Student Health Clinic is closed or not accessible.

Treatment or Service means confinement, treatment, service, substance, material, or device prescribed according to the Generally Accepted medical practice for the diagnosis or treatment of a Sickness.

Usual, Reasonable and Customary (URC) means:

- charges and fees for medical services or supplies that are the lesser of: (i) the usual charge by the provider for the service or supply given; (ii) or the average charges for the service or supply in the area where service or supply is received; and
- treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

Wellness Benefit Limit means the overall maximum of benefits payable for Covered Charges per Coverage Period under this Plan as listed on the CSB.

You, you or your refers to a Student covered under this Plan.

COVERED CHARGES

Covered Charges will be the actual cost charged to you for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Usual, Reasonable or Customary (URC) charges for:

- Hospital semi-private room and board;
- Hospital services other than room and board;
- Birthing Center services;
- Ambulatory Surgery Center services;
- the services of a Physician, including Physician Visits;
- the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided during confinement in a Hospital;
- the services of licensed respiratory and rehabilitation therapists;
- the services of licensed physical, occupational, and speech therapists;
- surgical dressings, covered orthotics, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
- anesthesia, blood, blood plasma, oxygen, and nebulizers and related charges;
- x-ray and laboratory examinations (This includes a professional component that is billed by a pathologist in connection with the laboratory testing.);
- x-ray, radium, and radioactive isotope therapy;
- wellness benefits for routine mammography screenings, routine pap tests, routine immunizations as recommended by the Center for Disease Control, and other wellness related services;
- the services of a Physician;
- drugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing;
- transportation services by ambulance provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care;
- Dental Services as listed on the CSB;
- Diabetic care: Diabetes Outpatient Self-Management Education, glucometer, disposable blood/urine glucose/acetone testing strips (not to exceed 50 per occurrence), and lancets; and
- Mental Health or Substance Abuse as listed on the CSB.

EXCLUSIONS

Covered Charges will not include and no benefits will be paid for Treatment or Service:

- that results from an accident;
- that is not for Medically Necessary Care;
- that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure described in the notice of that claim decision);
- any part of a charge that exceeds Usual, Reasonable or Customary (URC) Charges;
- the services of any person in your Immediate Family;
- for Cosmetic Treatment and Services;
- for educational or training problems, learning disorders, marital counseling, or social counseling;
- for which you have no financial liability or that would be provided at no charge in the absence of coverage;
- that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law);
- that results from war or act of war or from participation in criminal activities;
- for Kerato-Refractive Eye Surgery for myopia (nearsightedness), hyperopia (farsightedness), or astigmatism;
- charges for telephone calls and/or telephone consultations;
- that results from a Sickness that is covered by a Workers' Compensation Act or similar law;
- related to the restoration of fertility or the promotion of conception, including in-vitro fertilization procedures and artificial insemination (except as described under Covered Charges);
- any nursing services (except as described under Covered Charges);
- for reversal of voluntary sterilization;
- tests and exams that are not due to or part of the treatment of a Sickness (except as provided under Covered Charges);
- charges for services or supplies for which benefits are not payable because of Deductible, Copayment, or Student Responsibility provisions under this Plan;
- Dental Services and materials, including dental implants, (except as described under Covered Charges); vision therapy, eye examinations for the correction of vision or the fitting of glasses; hearing aids; vision materials (including but not limited to frames or lenses); drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing; vitamins and minerals (that do not require a Physician's prescription); nutritional supplements (even if the only source of nutrition) or special diets (whether they require a Physician's prescription or not); wigs or hair prostheses; and comfort or convenience services and supplies;
- that results from the abortion of a pregnancy, except that benefits will be payable for the abortion only if continuation of the pregnancy would endanger the life of the mother;
- barrier-free home modifications whether or not recommended by a Physician, including but not limited to, ramps, grab bars, railing, or standing frames;
- sexual disorder therapy;

- for smoking cessation or nicotine addiction, gambling addiction, or stress management;
- for insertion, removal, or revision of breast implants, unless provided post-mastectomy;
- missed appointments;
- for any Sickness for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the Sickness occurs post-mastectomy;
- non-implantable communicator-assist devices, including but not limited to, communication boards, and computers;
- for work-hardening services or vocational rehabilitation programs;
- for developmental delay;
- leading to, in connection with, or resulting from sexual transformation or intersex surgery;
- for custodial care;
- for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained;
- cryopreservation or storage;
- for and complications related to:
  - human-to-human organ or bone marrow transplants;
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of artificial or mechanical devices designed to replace human organ(s).
- charges for e-mail communication or e-mail consultation;
- charges for Physician overhead, including but not limited to equipment used to perform the particular Treatment or Service (e.g., laser equipment);
- for non-synostotic plagiocephaly (positional head deformity);
- charges for heating pads, heating and cooling units, ice bags or cold therapy units;
- for unattended home sleep studies;
- charges for travel and lodging;
- molecular genetic testing (specific gene identification) for the purposes of health screening or if not part of a treatment regimen for a specific Sickness;
- for standby services;
- charges for motorized carts, scooters, or strollers;
- additional charges incurred because care was provided after hours, on a Sunday, holidays, or weekend;
- for gynecomastia (abnormal breast enlargement in males);
- congenital conditions;
- preventive medicines, sera or vaccines unless specifically provided in the CSB;
- replacement or removal of hair growth, alopecia;
- services and supplies for conditions related to learning disabilities; or
- weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

COORDINATION WITH OTHER PLAN BENEFITS

Intent

The intent of this Plan is to supplement any Other Plan of benefits you are eligible to receive. This Plan provides benefits that offset deductible, co-pay and co-insurance obligations from the Other Plans that would otherwise deter you from seeking Medically Necessary Care. Coordination with Other Benefits is to provide that the sum of benefits paid under the Plan plus benefits paid under all Other Plans will not exceed the lesser of the financial liability of you for the Usual, Reasonable and Customary charge for a Treatment or Service.

Your benefits are payable for Covered Charges not otherwise covered and payable by any Other Plan providing medical expense benefits. If there are no other valid and collectible benefits available from any other source, this Plan will pay the Covered Charges up to the limits listed on the CSB. If there are other valid and collectible benefits available from any other source, the Plan will pay in excess of any amount unpaid by the Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which you are entitled, whether or not a claim is made for the benefits.

The Sponsor funding this Plan reserves the right to waive this provision of the Plan.

Exchange of Information

Any person who claims benefits under the Plan must, upon request, provide all information that is needed to coordinate benefits.
In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

Right of Recovery

If it is determined that benefits paid under the Plan should have been paid by an Other Plan, the Sponsor will have the right to recover those payments from:

- the person to or for whom the benefits were paid; and/or
- the other companies or organizations liable for the benefit payments.

SUBROGATION AND REIMBURSEMENT

Applicability

This section will apply if you:

- receive benefit payments under this Plan as the result of a Sickness; and
- have a lawful claim against another party or parties or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same Sickness.

The Plan will have the first priority right of reimbursement, regardless of whether or not (1) you have been fully compensated, or "made-whole" for your loss; (2) liability for payment is admitted by you or any other party; or (3) the recovery by you is itemized or called anything other than a recovery for medical expenses.

When benefits are paid to you under the terms of the Plan, the Sponsor shall be subrogated, unless otherwise prohibited by law, to the rights of recovery against any person who might acknowledge liability or is found legally liable by a court of competent jurisdiction for the Sickness that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by the Sponsor of the benefits paid for such hospitalization and treatment and the Sponsor will pay fees and costs associated with such recovery.

Right of Recovery

If it is determined that benefits paid under this Plan should have been paid by any Other Plan, the Sponsor will have the right to recover those payments from:

- the person to or for whom the benefits were paid; and/or
- the other companies or organizations liable for the benefit payments.

Transfer of Rights

In those instances where this section applies, you agree to transfer your rights to the Sponsor. Your rights to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Sponsor, but only to the extent of benefit payments made under this Plan.

Student Obligations

To secure the rights of the Sponsor under this section, you must:

- Complete any applications or other instruments and provide any documents the Sponsor or Claims Administrator might require, and cooperate with the Sponsor or Claims Administrator and their agents in order to protect the subrogation rights of this Plan.
- If payment from the other party or parties has been received, reimburse the Sponsor for benefit payment made under this Plan (but not more than the amount paid by the other party or parties).
- You will not take any action that prejudices the rights of this Plan. If you enter into litigation or settlement negotiations regarding obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan.

The costs of legal representation retained by the Sponsor in matters related to subrogation will be borne solely by the Sponsor. The costs of legal representation retained by you will be borne solely by you.

CLAIM PROCEDURES

Claim Reporting Form

You are required to file one complete claim reporting form for each Coverage Period. The claim reporting form and claim filing instructions may be found on the Sponsor's website of the CSB.

Claim Procedures

Once you have filed a complete claim reporting form for a Coverage Period, to file a subsequent claim for benefits under the Plan you must:

- report your Sickness to Student Health Clinic;
- file all charges with your primary insurance carrier (you may need to obtain pre-authorization for services rendered to avoid a reduction in benefits); and
- if your primary insurance carrier does not pay all of your bill, submit a copy of the itemized bill along with a copy of their Explanation of Benefits (EOB) to the Claims Administrator at:

NAHGA Claim Services
P.O. Box 189
Attn: Claims Dept.
Bridgton, ME 04009-0189

Phone: (877) 497-4980
Fax: (207) 647-4569
Email: eiia@nahga.com

Please be sure that the itemized insurance bills include your name, the Sponsor's name, and your student ID number. Identify all subsequent information relating to your claim with your name; the Sponsor's name; your student ID number, the identity of the provider and the date of Treatment or Service. Please do not submit duplicate claim forms.

Payment, Denial, and Review

Up to 30 calendar days from receipt of claim is permitted for processing the claim. If a claim cannot be processed due to incomplete information, the Claims Administrator will either deny the claim or send a written explanation prior to the expiration of the 30 calendar days. If the Claim Administrator does not deny the claim and requests additional information to complete the review, you are then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

You may request a review of a claim denial by written request to the Claims Administrator within 30 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to complete the review. The Claims Administrator will notify you in writing of its decision within 60 calendar days of receiving the review request.

After exhaustion of the review process, you may request an appeal. The appeal must be requested in writing to the Plan Administrator. You may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan Administrator will make a determination within 60 calendar days of request for an appeal. However, if the appeal cannot be processed due to incomplete information, the Plan Administrator will send a written explanation of the additional information that is required or

an authorization for your signature so information can be obtained from the provider. This information must be sent to the Plan Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in the denial of your claim. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of an appeal is voluntary and does not negate your right to request arbitration following the review, nor does it have any effect on your right to any other benefit under the Plan. The appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At any time during the appeal process, you may file a request with the Plan Administrator for arbitration.

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

You agree to be bound by this Binding Arbitration provision and acknowledge that you each giving up your right to a trial by court or jury.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

You begin arbitration by making a written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in Chicago, Illinois according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of you and the Plan Administrator, or by order of the court, if you and the Plan Administrator cannot agree. The arbitration will be held at a time and location mutually agreeable to you and the Plan Administrator.

Facility of Payment

Benefits will normally be paid to your medical provider. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Sponsor to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at the Claims Administrator's option, be paid to your estate, spouse, child, parent, or provider of medical and dental services.
- If the Claims Administrator believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Claims Administrator may pay whoever has assumed the care and support of the person.

Legal action for a claim may not be started until after arbitration and in no event earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been

exhausted. Further, no legal action may be started later than 12 months after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

Right of Recovery

If it is determined that benefits paid under this Plan are in excess of benefits that should have been paid, the Sponsor will have the right to recover those payments from the person to or for whom the benefits were paid.

PLAN ADMINISTRATION

Allocation of Authority

The Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator shall have the sole and exclusive right and discretion:

- to interpret the Plan, the CSB and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions; and
- to make factual findings and decide conclusively all questions regarding any claim for benefits made under the Plan.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the Plan will be conclusive and binding on all persons.

Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

- to require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan;
- to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the Plan;
- to decide on questions concerning the Plan, or the eligibility of any person to participate in the Plan, in accordance with the provisions of the Plan;
- to determine the amount of benefits that will be payable to any person in accordance with the provisions of the Plan;
- to inform any Student of the amount of such benefits payable in accordance with the provisions of the Plan;
- to provide a full and fair review to any Student whose claim for benefits under the Plan has been denied in whole or in part;
- to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan;
- to retain such actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration; and
- to perform any other functions or actions that would commonly be within the purview of a similarly situated administrator for a student benefits plan.

Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan.

The Plan Administrator also will have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as Medical Necessity or Experimental treatments.

The Plan Administrator (and any person to whom any duty or power in connection with the operation of the Plan is delegated) may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly-appointed actuary, accountant, consultant, third-party administration service, legal counsel, or other specialist, and the Plan Administrator or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance upon such table, valuations, certificates, etc.

Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person will incur any liability for any acts or failure to act under the terms of this Plan.

GENERAL PROVISIONS

Terms of Coverage

- In order for you to be entitled to benefits under the Plan, both the Plan and your coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the Treatment or Service for which the charge is made.
- The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

Benefits Not Transferable

Only you are entitled to receive benefits under this Plan. Your right to benefits cannot be transferred in whole or in part to any person, nor may the benefits of this coverage be transferred, either before or after Covered Charges are rendered without the written consent of the Claims Administrator. Benefits for Covered Charges will be issued directly to the medical provider unless a paid receipt for the Covered Charges is submitted with the claim.

Application of ERISA and Other Laws

The Plan is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the Plan. Similarly, as a self-funded program, the Plan is not subject to state insurance laws.

Plan Funding

All benefits paid under the Plan shall be paid in cash directly from the Sponsor or from a designated fund established and maintained by the Sponsor. No person shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that Sponsor may purchase, establish, or accumulate to aid in providing benefits under the Plan. No person shall acquire any interest greater than that of an unsecured creditor.

Effect of Plan

Any and all rights provided to you under the Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Sponsor and you nor shall it be consideration or an inducement for your initial or continued enrollment. Likewise, maintenance of this Plan shall not be construed to give you the right to be retained as a Student by the Sponsor or the right to any benefits not specifically provided by the Plan.

Waiver and Estoppel

No term, condition, or provision of the Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and it shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Student other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

Headings

All section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

Notices

All notices to the Claims Administrator shall be sent to:

NAHGA Claims Services
P.O. Box 189
Attn: Claims Dept.
Bridgton, ME 04009-0189

All notices to the Plan Administrator shall be sent to:

Educational and Institutional Insurance Administrators, Inc.
200 S. Wacker Drive
Suite 1000
Attn: Mary Ellen Moriarty
Chicago, IL 60606