



BOISE STATE UNIVERSITY

“the Policyholder”

Student Health Insurance Plan (SHIP)

2009-2010

Premium for Basic coverage is paid on a per semester basis.

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

Administrator Policy No.: AIH0069310
Reference No.: CAS9710659

Please keep this brochure as a general summary of the insurance.
(S30494NUFIC-ID-BSU)

INTRODUCTION

Maksin Management Corp has been selected to administer the Student Health Insurance Plan (SHIP) for Boise State University students. Students will be able to utilize the on-campus services provided by University Health Services (UHS), as well as receive the additional benefits outlined in this brochure. UHS services are available only to Boise State University students.

**For information regarding the array of services provided at UHS, please contact:
Boise State University – SHIP Office
2103 University Drive
Boise, ID 83706
Phone: 1-208-426-2158
Email: ship@boisestate.edu**

This brochure is only a brief description of the coverage available under policy series S30494NUFIC. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions, some of which may not be included in this brochure. Full details of the coverage are contained in the Policy on file at the University. If any discrepancy exists between the contents of this brochure and the Policy, the Policy will govern in all cases.

ELIGIBILITY

Idaho State Board of Education policy requires full-fee-paying students (defined as 12+ credits for undergraduate students and 9+ credits for graduate students) attending classes in Idaho maintain adequate health insurance. All full-fee paying students, all international students, and all intercollegiate student athletes are automatically enrolled in the Boise State University Student Health Insurance Plan (SHIP).

The annual student premium for the Basic SHIP coverage is \$1,570. Each semester, half the premium is included in the tuition fee bill. Premium for Basic coverage is paid on a per semester basis.

Full-fee-paying and international students who are currently insured by a health insurance policy may waive SHIP with proof of continuous enrollment in an alternate U.S.-based insurance plan with comparable benefits. Comparable coverage for international students must include repatriation and medical evacuation benefits. Students may test for comparability of their alternate coverage and view coverage recommendations at www.boisestate.edu/healthservices/insurance/index.asp.

Intercollegiate student athletes are not allowed to waive SHIP coverage. **Waiver applications must be filed by the 10th day of classes to disenroll from SHIP.**

An eligible student must attend classes at the University for at least the first 31 days of the period for which he or she is enrolled. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 31 days of the period for which he or she is enrolled will not be covered under the Policy and a full refund of premium will be made. Students who withdraw after such 31 days will remain covered under the Policy and no refund will be made. Home study, correspondence, Internet and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been and continue to be met. If the Company discovers that the Policy eligibility requirements have not been or are not being met, its only obligation is to refund premium, less any claims paid. A Covered Student must meet the eligibility requirements each time he or she pays premium to continue insurance coverage. Eligible Covered Persons will be covered for the policy term for which they are enrolled and for which premium has been paid.

Eligible students who do enroll may also insure their eligible Dependents. A newborn natural child, adopted child, or child placed for adoption is covered for Injury or Sickness from birth until 60 days old. Coverage may be continued for that child when

the Company is notified in writing within 60 days from the date of birth and required premium is paid. The due date of any additional premium required for the newborn or adopted child's insurance to continue shall be not more than 31 days following the receipt by the Covered Student of the Company's written notice of the additional premium due.

An Optional Catastrophic Coverage benefit is made available only for those students and their eligible Dependents enrolled for the Basic SHIP coverage with payment of an additional premium. This optional coverage may only be purchased simultaneously and in conjunction with the purchase of the Basic SHIP coverage. **Enrollment is on an annual basis and only offered during the fall semester open enrollment period. Coverage under the Optional Catastrophic Coverage terminates at the same time Basic SHIP coverage is terminated.**

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on August 1, 2009 and terminates at 11:59 p.m. on August 14, 2010.

Intercollegiate Student Athletes and Eligible Dependents

Coverage becomes effective at 12:01 a.m. on August 1, 2009 and terminates at 11:59 p.m. on July 31, 2010. Refunds of premiums are allowed only upon entry into the armed forces (the Company will refund the unearned, pro-rata premium to such person upon written request and receipt of appropriate proof of service within 30 days of leaving school) or if eligibility requirements are not met.

Domestic Full-Time Students, International Students and Eligible Dependents

Coverage becomes effective at 12:01 a.m. on August 15, 2009 and terminates at 11:59 p.m. on August 14, 2010. Refunds of premiums are allowed only upon entry into the armed forces (the Company will refund the unearned, pro-rata premium to such person upon written request and receipt of appropriate proof of service within 30 days of leaving school) or if eligibility requirements are not met.

Coverage effective dates for Covered Students and their eligible Dependents will be the latest of: a) the effective date of the Master Policy; or b) the effective date of the term of coverage for which premium has been paid for the Covered Person; or c) the day after the date the enrollment form and correct premium are received; or d) the date the student becomes eligible for coverage.

Coverage terminates at the earliest of: a) the termination date of the Master Policy; or b) the last day of the term of coverage for which premium has been paid for the Covered Person; c) the date the Covered Person ceases to be eligible; or d) the date a Covered Person enters full time, active military service.

Waiver /Optional Enrollment Deadlines

Academic Term:

- Fall 2009: September 4, 2009
- Spring 2010: February 1, 2010

No online waiver application submission will be accepted beyond the above-specified dates. Log onto BroncoWeb to submit your waiver request. Log onto www.maksin.com/BSU.aspx for optional coverage enrollment submissions. Dependent coverage may only be purchased simultaneously and in conjunction with the purchase of Basic SHIP coverage by the student. Dependent eligibility expires concurrently with that of the Covered Student except as specifically provided under the Extension of Benefits provision. The only enrollment exceptions are during a special enrollment period when one of the following qualifying events occurs: a) adding a new spouse (within 60 days of marriage); b) birth of a newborn child, legal adoption or placement for adoption of a child (within 60 days of the event); or c) loss of coverage under another creditable plan due to ineligibility

(within 31 days). For a qualifying event enrollment, please contact Maksin Management Corp at 1-877-775-5430.

It is the Covered Person's responsibility to assure timely renewal payments to avoid a lapse in coverage. A lapse in coverage will subject claims to the pre-existing condition clause.

COORDINATION OF BENEFITS

The Policy pays primary, however, it will coordinate benefits with any valid and collectible insurance or plan as outlined in the Master Policy so that combined payments under all programs will not exceed 100% of charges incurred for Eligible Expenses. The Master Policy is on file at the University.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under the Policy is "Creditable Coverage" under Federal Law. When coverage terminates, the Covered Person can request a Certificate of Coverage that is evidence of coverage under the Policy. 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 the coverage under the Policy terminates. If the subsequent health plan excludes or limits coverage for medical conditions the Covered Person had before enrolling, this Certificate may be used to reduce or eliminate those exclusions or limitations.

In order to obtain a Certificate of Creditable Coverage, please contact Maksin Management Corp, P.O. Box 2617, Camden, NJ 08101 or call 1-877-775-5430.

NON-DUPLICATION OF COVERAGE

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

EXTENSION OF BENEFITS AFTER TERMINATION

If, on the date coverage terminates, a Covered Person is Totally Disabled as a result of Sickness or Injury and is receiving treatment for such Sickness or Injury, benefits will be payable for the Eligible Expenses incurred for that Sickness or Injury after the date coverage terminates until the earliest of the following: (1) the end of the Sickness or Injury that caused the Total Disability;(2) the end of the 12 month period following the date the coverage terminated; or (3) the date the applicable Maximum Amount is reached.

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

CONTINUATION PRIVILEGE AFTER GRADUATION

If the Covered Student (and Covered Dependents) becomes ineligible under this plan by graduating, he or she is eligible for up to 3 months of coverage under a Continuation Plan. Payment for coverage under the Continuation Plan must be made from the date the Covered Student ceases to be a Covered Person under the Student Health Insurance Plan. Written application for a Continuation Plan must be made to Maksin Management Corp no later than 31 days after the Covered Student ceases to be eligible under the plan. Continuation of Coverage will be subject to the terms of the Policy. Contact Maksin Management Corp at 1-877-775-5430 for assistance.

STATE MANDATED BENEFITS

The Policy covers the following State of Idaho mandates: Mammography at age-specific intervals and any other applicable mandated benefits. See the Policy on file at the University for details.

DEFINITIONS

"Accident" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

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

"Copayment Amount" means the initial dollar amount paid by the Covered Person for an Eligible Expense at the time service is rendered.

"Covered Person" means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

"Covered Student" means a student of the Policyholder who is insured under the Policy.

"Deductible/Deductible Amount" means the dollar amount of Eligible Expenses a Covered Person must pay during each Policy Year before benefits become payable.

"Dependent" means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's unmarried child under age 25 for whom the parent (Covered Student or his or her Spouse) provides more than one-half (1/2) of his or her financial support.

An unmarried child of any age is a dependent if he or she is medically certified as disabled and financially dependent upon the Covered Student.

The term "child" includes:

- (a) a Covered Student's legally adopted child;
- (b) child who has been Placed with the Covered Student; and
- (c) a Covered Student's step-child if such child resides with the Covered Student and depends on the Covered Student for support.

"Placed" means physical placement in the care of the Covered Student, or in circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a Hospital, it shall mean when the Covered Student signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

"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.

"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) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

"Emergency Medical Condition" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health or pregnancy of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious impairment or dysfunction of any bodily organ or part of such person.

"Experimental/Investigational" means a drug, device or medical care or treatment that meets the following: (a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; (b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law; (c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care

or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval; (d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or (e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; and (b) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is Experimental/Investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

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

“Pre-Existing Condition” means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the Covered Person's effective date of coverage.

“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.

“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and involuntary complications of pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

“Totally Disabled” and “Total Disability” means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a student: from attending classes at the location where he or she is enrolled; and (b) with respect to a Dependent, or a student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex.

PREFERRED PROVIDER ORGANIZATION

In an effort to control insurance medical costs and enhance payment, this Plan has implemented a Preferred Provider Organization (PPO) of hospitals, facilities and Doctors who have contracted to provide specific medical care at a discounted, negotiated rate to Covered Persons eligible for benefits. No referrals are required, and the preferred provider will submit claims for payment on your behalf.

Before obtaining services, you should always verify the current network status of a provider as a provider's status may change. You can verify the provider's status by calling the PPO's toll-free telephone number or directly contacting the provider's office.

IDAHO (INSIDE IDAHO):

Preferred Provider Organization: Idaho Physicians Network (IPN)

Toll-Free Telephone Number: 866-476-1076

Network Website: www.ipnmd.com

NATIONWIDE (OUTSIDE OF IDAHO):

Preferred Provider Organization: First Health Network

Toll-Free Telephone Number: 800-226-5116

Network Website: www.firsthealth.com

If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the non-network level of benefits shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO hospital, it does not guarantee that all providers at the hospital are participating providers. In addition, if a Covered Person is referred by a participating provider to another facility or provider, it does not mean that the provider or facility to which the Covered Person is referred is also a participating provider. It is the Covered Person's responsibility to verify that the provider is currently part of the PPO.

PHARMACY NETWORK

Pharmacy Benefit Manager: Express Scripts, Inc.

Website: www.express-scripts.com

Toll-free telephone number: 1-800-451-6245

The prescription benefits stated in this plan are based upon prescriptions being filled by a participating pharmacy only. There is no non-participating pharmacy benefit. A list of participating pharmacies is available for your review at www.express-scripts.com or at www.maksin.com/BSU.aspx.

Retail Participating Pharmacy: Each prescription and each refill is limited to a 30-day supply per month. Simply present your member ID Card at the pharmacy.

Mail Order: Each prescription and each refill is limited to a 90-day supply.

With mail order home delivery, prescriptions are directly delivered to your home with free standard shipping. Once you begin using home delivery, you can order refills online or by phone. Have prescriptions delivered to your home in either of the following two ways: **Online:** 1) visit www.express-scripts.com; and 2) activate your account; and 3) follow the prompts to change prescriptions to home delivery or fill a new prescription. **By mail:** 1) ask your Doctor to write a prescription for up to a 90-day supply of your medication (plus refills for up to one year, if appropriate); 2) complete a home delivery form; and 3) mail your completed form, prescription and co-payment to Express Scripts. When your order is received, your prescription will be filled and sent to you in seven to ten days. If you need an order form, please visit www.express-scripts.com to print one or call the provided toll-free number.

SCHEDULE OF BENEFITS: BASIC COVERAGE

The Plan Pays Eligible Expenses at Applicable Coverage Percentage after the Deductible.

Benefits will be paid as allocated for each service as scheduled below.

Dependents are not eligible to receive services at University Health Services (UHS)

BENEFIT	UHS	IN-NETWORK	NON-NETWORK
Aggregate Maximum Per Policy Year (all conditions combined) \$100,000 Maximum Benefit* *ICS Injuries are limited to \$75,000			
Deductible Per Policy Year (in-network and non-network deductibles apply separately)	N/A	\$250 Per Covered Person	\$500 Per Covered Person
Out-of-Pocket Limit Per Policy Year (excludes deductibles; in-network and non-network out-of-pocket limits apply separately)	N/A	\$4,000 Per Covered Person	\$6,000 Per Covered Person
INPATIENT ELIGIBLE MEDICAL SERVICES			
Room and Board and general nursing care provided and charged by the hospital: limited to average daily semi-private room rate (except ICU).	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Hospital Miscellaneous: includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays (including professional fees); oxygen tent; drugs (excluding take-home drugs), medicines, dressings; and other Medically Necessary and prescribed hospital Expenses.	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Skilled Nursing Facility/Rehabilitation Care Expense: includes room and board and general nursing care provided and charged by the facility and hospital miscellaneous services. (Limited to 60 days per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Surgeon / Assistant Surgeon Fees When Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay full value for the primary procedure performed and 50% of the value for the second procedure performed and 50% of the value for any additional procedures performed.	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Anesthesia: professional services	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Doctor's Visits: benefits do not apply when related to surgery. (Limited to one visit per day)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Physiotherapy	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Pre-Admission Testing: hospital confinement must occur within 7 days of the testing	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Mental & Nervous Disorders and/or Substance Abuse Services: for inpatient or intermediate care (Limited to 30 days per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
OUTPATIENT ELIGIBLE MEDICAL SERVICES			
Day Surgery Miscellaneous: when scheduled surgery is performed in a hospital or outpatient facility, including the use of the operating room, laboratory tests and x-ray examinations (including professional fees), anesthesia, drugs or medicines and supplies, therapeutic services (excluding Physiotherapy or take home drugs and medicines). Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index.	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Surgeon / Assistant Surgeon Fees When Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay full value for the primary procedure performed and 50% of the value for the second procedure performed and 50% of the value for any additional procedures performed.	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Anesthesia: professional services	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Doctor's Office Visits: benefits do not apply when related to surgery. (Limited to one visit per day)	100% of Eligible Expenses	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Routine Wellness Examinations at UHS ONLY: includes Doctor's office visit and UHS-referred routine Diagnostic X-Ray and Laboratory Tests**	100% of Eligible Expenses	Not Covered	Not Covered
Injections: when administered in the Doctor's office when no other service is received (includes allergy immunotherapy).	100% of Eligible Expenses	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Hospital Emergency Room and Non-Scheduled Surgery: for use of hospital Emergency Room, operating room, laboratory and x-ray examinations, supplies. If treatment is received in a non-network facility due to an Emergency Medical Condition, benefits for Eligible Expenses are payable at the in-network level of benefits.	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Urgent Care Center	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Laboratory Tests: (UHS sends certain lab tests off-site for processing; these fees are payable at the 80% in-network level of benefits and subject to the deductible)	100% of Eligible Expenses	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Diagnostic Services: includes X-Rays, CATS cans, PETS cans, MRI and Nuclear Medicine	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Testing for Disorders: includes Doctor's visits and related laboratory expenses for eating, learning, and sleep disorders.	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Radiation Therapy/Chemotherapy	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Prescription Drug Card – Express Scripts Pharmacy Network: (Limited to \$400 per Policy Year). Each prescription/refill is limited to 30-day supply; Mail Order is limited to 90-day supply. However obtained, all Outpatient Drugs, except for infusion therapy drugs, are subject to the Outpatient Prescription Drug Maximum.	N/A	\$10 Generic / \$20 Brand Copayment Mail Order 2X Copayments	Not Covered
Rehabilitation Services: includes benefits for rehabilitation services that are expected to result in significant physical improvement within 2 months of the start of treatment. Including:			
• Physical Therapy (Limited to 20 Visits per Policy Year outside of UHS)	100% of Eligible Expenses	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
• Massage Therapy (Limited to 20 Visits per Policy Year)	100% of Eligible Expenses	Not Covered	Not Covered
• Occupational Therapy (Limited to 20 Visits per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
• Speech Therapy: payable only when the speech impediment or speech dysfunction results from Injury, stroke, autism or a congenital anomaly. (Limited to 20 Visits per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
• Pulmonary Therapy (Limited to 20 Visits per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
• Cardiac Therapy (Limited to 36 Visits per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Chiropractic Care: includes diagnosis and related services (Limited to 1 visit and treatment per day; up to 24 Visits per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Mental & Nervous Disorders and/or Substance Abuse Services (Limited to 20 Visits per Policy Year Outside of UHS)	100% of Eligible Expenses	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
OTHER ELIGIBLE MEDICAL SERVICES			
Ambulance Services: Ground / Air (Emergency Medical Condition Only)	N/A	80% of Allowable Charges (After Deductible)	Same as In-Network
Dental Expense: for Injury to sound, natural teeth and extraction of impacted wisdom teeth only. Dental services to repair damage caused by an Accident must be started within 3 months of the Accident and completed within 12 months of Accident.	N/A	80% of Allowable Charges (After Deductible)	Same as In-Network
Infusion Therapy: includes all related services, supplies and drugs (Limited to \$3,000 per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Durable Medical Equipment / Braces and Appliances: 1) Limited to a single purchase (including repair/replacement) of each type per Policy Year; must be ordered or provided by the attending Doctor for outpatient use; and 2) Diabetic Supplies when prescribed by attending Doctor. (Limited to \$2,500 per Policy Year).	100% of Eligible Expenses	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Prosthetic Devices (Limited to a single purchase of each type of prosthetic device Per Policy Year up to \$2,500 per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Maternity	N/A	Paid as any other Sickness	Paid as any other Sickness
Home Health Care (Limited to 60 visits per Policy Year)	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)
Hospice Care	N/A	80% of Allowable Charges (After Deductible)	50% of R&C Charges (After Deductible)

**Student only benefit

OPTIONAL ATHLETIC SUPPLEMENTAL COVERAGE ICS STUDENT ATHLETES ONLY

This optional coverage is subject to payment of an additional premium. This coverage may only be purchased, and would terminate, simultaneously and in conjunction with the Basic Student Health Insurance Plan (SHIP).

After the Basic SHIP per policy year deductible has been met, the Company will pay 100% of Allowable Charges for in-network providers and 70% of Reasonable and Customary Charges for non-network providers for Eligible Expenses under the Policy. Benefits will be paid as allocated for each service under the Basic SHIP coverage.

OPTIONAL CATASTROPHIC COVERAGE \$500,000 MAXIMUM BENEFIT PER POLICY YEAR

This optional coverage is subject to payment of an additional premium. This coverage may only be purchased simultaneously and in conjunction with the Basic SHIP during the fall semester open enrollment period. Coverage will terminate simultaneously and in conjunction with the Basic SHIP although the Optional Catastrophic Coverage is purchased on an annual basis.

This coverage begins payment after the aggregate Basic SHIP maximum benefit of \$100,000 has been paid by the Company. The Company will pay 80% of the Eligible Expenses in-network and 50% of the Eligible Expenses non-network up to an additional maximum benefit of \$400,000 for a combined Plan maximum of \$500,000 per Policy Year. Benefits will be paid as allocated for each service under the Basic SHIP Coverage. No payments are payable for Intercollegiate Sports (ICS) Injuries under the Optional Catastrophic Coverage.

EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment, or dental x-rays except for treatment resulting from Injury to sound, natural teeth or for extraction of impacted wisdom teeth as specifically provided in the Policy.
2. for eye examinations, eyeglasses, contact lenses, radial keratotomy or laser surgery or prescriptions or examinations for such 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. Eye refraction is not covered.
3. for hearing examinations or hearing aids; tinnitus maskers or examinations for prescribing them; 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.
4. for Injury or Sickness resulting from war or act of war, declared or undeclared.
5. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
6. 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.
7. for treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of insurance.
8. for any cosmetic procedure. "Cosmetic procedure" means a service or procedure designed to change or improve appearance without significantly improving physiological function. It includes, but is not limited to: pharmacological regimens, nutritional procedures or treatments; scar or tattoo removal or revision provision (such as salabrasion, chemosurgery and other such skin abrasion surgery); replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure; weight loss programs whether or not they are under medical supervision; and wigs, regardless of the reason for the hair loss. It does not include

reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent child; breast reconstructive surgery after a mastectomy; or replacement of an existing breast implant if the initial breast implant followed a mastectomy.

9. for Injuries sustained as the result of a motor vehicle Accident wherein the Covered Person participates as a professional driver to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
10. for preventive treatment, testing, medicines, serums, vaccines, vitamins or oral contraceptive, except as specifically provided in the Policy.
11. for Elective Treatment or elective surgery unless otherwise provided in the Policy.
12. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
13. for services normally provided without charge by the school and covered by the school fee for services.
14. for any services rendered by a Covered Person's immediate family member.
15. for a treatment, service or supply which is not Medically Necessary.
16. for personal items or services such as television, telephone or transportation.
17. for treatment of temporomandibular joint dysfunction and associated myofascial pain.
18. for treatment of Mental or Nervous Disorders except as specifically provided in the Policy.
19. for the treatment of alcoholism or substance abuse except as specifically provided in the Policy.
20. for or in relation to orthopedic shoes or devices intended to be placed inside shoes or other footwear.
21. for surgery and/or treatment of: acupuncture; gynecomastia; breast implants or breast reduction unless Medically Necessary following a mastectomy; corns, calluses and bunions; family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; impotence, organic or otherwise; nonmalignant warts, moles and lesions unless Medically Necessary; premarital examinations; sexual reassignment surgery and related therapy; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; smoking cessation; tubal ligation; circumcision except as specifically provided in the Policy; vasectomy; hyperhidrosis; snoring, except when provided as part of treatment for documented obstructive sleep apnea; acupressure; aroma therapy; hypnotism; massage therapy except as specifically provided at UHS; and rolfling.
22. for routine physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy.
23. 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 in the Policy.
24. in connection with birth control, sterilization or sterilization reversal, including surgical procedures and devices except as specifically provided at UHS.
25. for maintenance therapy which is defined as those therapy services rendered to a Covered Person who is no longer making documentable progress to maintain the level of progress previously attained.
26. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intra-fallopian transfer and in vitro fertilization, or any other form of assisted conception, elective sterilization or its reversal, artificial insemination or in vitro fertilization.
27. for organ, tissue and cell transplants.

28. for elective abortion, except to preserve the life of the female upon whom the abortion is performed.
29. for rest cures or custodial care.
30. for surgical and non-surgical treatment of obesity (including morbid obesity), including, but not limited to the following: removal of excess skin and tissue resulting from weight loss, weight reduction or dietary control programs, prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements and any complication resulting from weight loss treatments or procedures.
31. for breast reconstruction and implantation or removal of breast prostheses unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.
32. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
33. for the services of a private duty nurse.
34. for routine foot care; treatment of flat feet or treatment of subluxation of the foot.
35. for oral appliances for snoring;
36. for psychosurgery.
37. for growth hormone therapy.

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 the Policy. This limitation will not apply if:

- (a) the Covered Person has been covered under the Policyholder's prior Policy for 12 consecutive months immediately preceding the effective date of coverage under the Policy; or
- (b) the individual seeking coverage under the Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. Credit will be given for the time the individual was covered under the prior Creditable Coverage; and the individual is not eligible for coverage under any other group health plan, Medicare or Medicaid; and the individual does not have other health insurance.

Pre-existing Conditions Limitation does not apply to:

- (a) a newborn Dependent child; or
- (b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under the Policy;
- (c) pregnancy or involuntary complications of pregnancy.

CREDIT FOR PRIOR COVERAGE: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under the Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

- (a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;

- (c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
- (e) a medical care program of the Indian Health Service or of a tribal organization;
- (f) a state health benefits risk pool;
- (g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
- (h) a public health plan as defined by federal regulations; or
- (i) a health benefit plan under section 5(e) of the Peace Corps Act.

CONTINUOUS COVERAGE

Continuously insured means a person who has been continuously insured under the Policy and prior Student Health Insurance policies issued to the school. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for expenses payable under prior policies in the absence of the current Policy. Previously insured Dependents and students must re-enroll for coverage in order to avoid a break in coverage within 31 days of the end of the prior coverage to maintain coverage for conditions which existed in prior Policy Years. Once a break in coverage in continuous insurance occurs, the definition of Injury or Sickness will apply in determining coverage of any condition that existed during such break.

SUBROGATION

If the Company has paid benefits to the Covered Person because of an Injury or Sickness, and in their opinion a third party may be liable, the Company will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of proceeds in any form from or on behalf of the third party including but not limited to recovery from any person, corporation, entity, no-fault coverage, uninsured coverage, other insurance policies or fund which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his or her rights to the Company. The Company will exercise such rights on his or her behalf. He or she further agrees to furnish the Company with all relevant information and documents.

REPATRIATION OF REMAINS BENEFIT

\$25,000 Maximum Amount Per Covered Person

If a Covered Person suffers loss of life due to Injury or Emergency Sickness while outside his or her home country, the Company will pay, subject to the Policy provisions, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person. Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible. Travel Assist must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Assist in advance.

EMERGENCY EVACUATION BENEFIT

\$25,000 Maximum Amount Per Covered Person

The Company will pay, subject to the Policy provisions, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. Travel Assist must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Assist in advance.

Please refer to the TRAVEL ASSIST SERVICES section of this brochure for information on how to contact Travel Assist for medical evacuation and repatriation benefit assistance.

COVERED PERSONS ARE ALSO ENTITLED TO THE FOLLOWING SERVICES:

TRAVEL ASSIST SERVICES

Procedures on How to Access Travel Assist Services 24-hour Assistance Call Center

How to Contact Travel Assist:

- Inside the U.S. and Canada, dial 1-877-249-5362 toll-free.
- Outside the U.S. 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 01-713-974-3422.

When to Contact Travel Assist:

- Call Travel Assist when you require medical assistance or have a medical emergency.
- Call Travel Assist for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Assist whenever there is a question.

Travel Assist 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 Services Medical Staff consists of full-time, onsite Registered Nurses and Emergency Doctors 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 doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide to Travel Assist when you call:

- Advise Travel Assist who you are insured by.
- Provide your Policy number, AIH0069310 / CAS9710659
- Advise Travel Assist regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Assist to call you back.

Description of Services

Information/General: These services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Assist 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 Assist also provides emergency message storage & relay and translation services.

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

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

- * Legal Referral
- * Embassy/Consulate Information

- * Lost/Stolen Luggage & Personal Effects Assistance
- * Lost Document Assistance
- * Cash Transfer Assistance
- * En-route Travel Assistance
- * Claims-related Assistance
- * Telephone Interpretation

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Assist's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include Doctor/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
- * Out-patient Assistance
- * In-patient Assistance

STUDENT ASSIST SERVICES

- **Concierge Services:** You receive the comforts, care, and attention of Student Assist'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 Student Assist's Personal Security Assistance at home or while traveling. To activate personal security services, please log on to: www.aig.com/personalsecurity. For initial setup, your login is "9710659" and the password is "security".

For more informative details visit Boise State University's personalized web page at www.maksin.com/BSU.aspx.

24-HOUR STUDENT EMERGENCY CARE HOTLINE

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

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

Comprehensive Resources and Advice from Registered Nurses

- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.
- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.
- Integrated phone access to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.

CLAIM FILING PROCEDURES

Claim forms can be accepted directly from providers if the claim form includes the name of the Covered Person, name of school under which the Covered Student is insured, identification number, date of services, diagnosis, treatment procedure and billed charges. Proof of loss must be furnished within 90 days after the date of such loss.

Submit claim forms to:

Maksin Management Corp

P.O. Box 2617

Camden, NJ 08101

Customer Service Toll-Free Telephone: 1-877-775-5430

Questions regarding benefits, specific claim information and periods of coverage should be directed to the address or Customer Service phone number previously listed.

Visit www.maksin.com/BSU.aspx to:

Access the following functions:

- Online Optional Catastrophic Coverage
- Online Optional Dependent Enrollment
- Optional Travel Assist Services Enrollment Form (applies only to International Students with alternate coverage without medical evacuation and repatriation benefits)
- Online Temporary ID Card

Review pertinent account information:

- Verification of Insurance
 - Claim Status
 - Plan Brochure
 - PPO Links
- Pharmacy Network Link

CLAIMS APPEAL PROCESS

Should a claim be denied, in whole or in part, the Covered Person has a right to a full and fair formal review. A written appeal must be submitted to include claimant's name, identification number, Policy number, claim number and provider's name as shown on the Explanation of Benefits (EOB).

The review will be conducted by someone different from the original decision maker(s) and without deference to the initial decision. An internal review is conducted by the claims supervisor upon receipt of a written appeal; the claims supervisor may also consult with the Director of Claims Operations. If a question of Medical Necessity is determined, or if a claim involves a highly specialized procedure, Maksin Management Corp will request a Peer Review or Independent Medical Review. If an appeal is in regards to benefit interpretation, the claims supervisor will work with the insurance carrier (the Company) for final resolution. The claims supervisor and the carrier will review all pertinent information and a formal response letter will be sent to the Covered Person detailing the decision and how the determination was derived.

A benefit determination will be made within 30 days following receipt of a written appeal. If the Covered Person is not satisfied with the outcome of the appeal, they may provide additional, pertinent written material to further substantiate their appeal, and a second review process will be initiated. A final benefit determination will be made within 30 days following receipt of the second written appeal.

The Covered Person, his/her designated representative, or a provider may also contact the Director of the Idaho Department of Insurance at any time.

At the Maksin Group, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more privacy information, please go to the website at www.maksin.com/BSU.aspx.

NON-RENEWABLE ONE YEAR TERM INSURANCE

The Policy is non-renewable one year term insurance. Similar coverage may be purchased for the following academic year. It is the Covered Student's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.