

Rosalind Franklin University of Medicine and Science

("the Policyholder")

**3333 Green Bay Road
North Chicago, IL 60064**

2009–2010

Student Accident and Sickness Insurance Plan

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

Administrator Policy Number: AMH0060780
Underwriter Reference Number: CAS9710543

This brochure is a general summary of the plan benefits and it is not intended as a Master Policy. The Master Policy on file at the University contains all of the definitions, provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between this brochure and the Master Policy, the Master Policy will govern in all cases.

INTRODUCTION

This brochure is a general summary of the Student Accident and Sickness Insurance Plan developed especially for the students of Rosalind Franklin University of Medicine and Science (RFUMS). The Master Policy issued to the University contains the complete details of coverage and is the governing document. It may be inspected during normal business hours at the University's Business Office. The Plan is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. with its principal place of business in New York, NY. The Plan is administered by Maksin Management Corp in Camden, NJ.

Two Plan options (Plan A and Plan B) are offered and it is up to each student to choose the Plan that best fits their needs. Plan A is recommended because it provides greater benefits; however, students can elect to purchase either Plan. A Covered Person will not be allowed to change choice of plans during any policy year. A change in choice of plans will only be allowed during the open enrollment period for the next policy year.

All full time students enrolled in twelve (12) or more credit hours are required to obtain and maintain health insurance while enrolled at RFUMS. Full time students that can demonstrate proof of other comparable coverage can waive out of the Plan. If an enrollment form or waiver form is not submitted by the applicable deadline, full time students will be automatically enrolled in Plan B and billed for each academic term on the quarterly tuition bill.

ELIGIBILITY AND ENROLLMENT/ WAIVER DEADLINES

All registered RFUMS students are eligible to enroll in the Plan. Health insurance coverage is voluntary for students registered for less than 12 credit hours per academic term.

Students enrolled in the Student Accident and Sickness Insurance Plan (Plan A or Plan B) may also cover their eligible dependents (see "Dependent" in Definitions Section). Coverage must be the same for the Covered Student and eligible Dependents. Dependent coverage must be purchased at the same time that the student enrolls in the Plan.

For continuing students, open enrollment occurs from July 1 through July 31, 2009; enrollment form or waiver form submission deadline is July 31, 2009. New incoming

students must submit their enrollment form or waiver form by the 10th business day after the effective date of the academic term for their specific program.

To enroll in the Plan, the eligible student must complete and sign an enrollment form and submit it to the University's Business Office by the applicable deadline. Appropriate premium will be included in the student's academic term tuition bill.

To waive the Plan, the student must complete and sign a waiver form and submit it to the University's Business Office by the applicable deadline along with proof of comparable coverage. Only full time students declining coverage under the Plan are subject to this requirement.

IMPORTANT: Insurance premium for Plan B will appear on a full time student's tuition bill unless he or she shows proof of comparable coverage and waives coverage under the University's sponsored Health Plan. If you have any questions, please contact the University's Business Office.

Students who purchase coverage under the Student Accident and Sickness Insurance Plan must actively attend classes or other required course work for at least the first 31 calendar days after his/her effective date of coverage.

The Company maintains the right to investigate student status and attendance records to verify that 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 refund of premium, less any claims paid.

Students may elect to purchase coverage after the enrollment deadline within 31 days of the following qualifying events* only:

- Within 31 days of changes in family composition due to marriage, birth or adoption of a child, or divorce.
- Loss of coverage under another creditable plan due to ineligibility.

*Proof is required at the time the enrollment form is submitted.

COVERAGE DATES

Effective Date of Insurance

The Insurance will become effective on the latest of:

- The Policy effective date: July 1, 2009, 12:01 a.m., or
- The date for which the first premium for the Covered Student's coverage is paid; or
- The effective date of the academic term for the Covered Student's specific program; or
- The date the Covered Student becomes eligible for coverage.

Termination Date of Insurance

The insurance will terminate on the earliest of:

- The last date for which premium has been paid for the Covered Person; or
- The date the Covered Person becomes ineligible for coverage; or
- The date the Covered Person enters military service*; or
- The termination date of the Policy: June 30, 2010.

*The Company will refund the unearned, pro-rata premium to such person upon written request and receipt of appropriate proof of service. This does not include Reserve or National Guard duty for training unless it extends beyond 31 days. Refunds of premium for Covered Students and Dependents are allowed only as stated above. No other refund will be permitted. Termination is subject to the Extension of Benefits provision.

PLAN FEATURES AND REQUIREMENTS

The cost containment features listed below are included in the Plan to keep your health care costs more affordable. Please take the time to read each so you will be familiar with your benefits:

1. PREFERRED PROVIDER ORGANIZATION (PPO)

Private Healthcare Systems (PHCS)

Customer Service 1-888-560-7427

Website: www.multiplan.com

The medical benefits stated in this plan are based upon medical treatment being received from a Preferred Provider Organization (PPO). If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or facility to which the Covered Person is referred is also a PPO provider. It is the Covered Person's responsibility to verify that the provider is part of the PPO. A list of nationwide PHCS Preferred Providers is available for your review via the internet at www.multiplan.com. Click on the logo provided on your ID card.

NOTE: 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.

2. PHARMACY NETWORK

Express Scripts, Inc.

Website: www.express-scripts.com

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 nationwide participating pharmacies is available for your review via the Internet at www.express-scripts.com.

Outpatient Prescription Benefit: Plan A and Plan B

Co-Payments per Prescription or Refill (After additional Rx Deductible).

Each prescription and each refill is limited to a 30 day supply

\$100 deductible per person per Policy Year THEN

\$15 co-payment generic

\$35 co-payment formulary brand

\$60 co-payment non-formulary brand

Mail order: 2x above co-payments for a 90-day supply

3. INPATIENT NOTIFICATION REQUIREMENT

All Inpatient stays should be reported.

The Covered Person is responsible for advising his or her Doctor of the in-patient notification requirement of this plan:

- Pre-Notification of Non-Emergency Hospitalizations: The Doctor or Hospital must telephone 1-877-775-5430 at least 5 days prior to the planned admission.
- Notification of Emergency Admissions: The patient, patient's representative, doctor or hospital must telephone 1-877-775-5430 within two (2) working days of admission.
- If the patient needs continued stay hospitalization beyond the time initially certified, additional necessary hospital days should be approved.
- If you fail to comply with the above guidelines, covered benefits will be reduced by \$150. The \$150 penalty does not apply toward meeting the deductible or co-insurance maximum.

IMPORTANT: Pre-Notification is NOT a guarantee that benefits will be paid.

Definitions

“Accident” means an occurrence which (a) is unforeseen; (b) is independent of Sickness, disease or bodily infirmity as cause of loss; and (c) causes Injury.

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

“Covered Person” means a Covered Student while coverage under this 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 this Policy.

“Dependent” means (a) the Covered Student’s spouse or domestic partner residing with the Covered Student; and (b) the Covered Student’s unmarried child under age 26 that is dependent upon the Covered Student for support. Newborn children and adopted children are covered for Injury or Sickness from birth until 31 days old. Coverage may be continued for that child when the Company is notified in writing within 31 days from the date of birth and required premium is paid.

“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 service within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s Immediate Family Member.

“Eligible Expense” means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury; (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while this 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 Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are suffi-

ciently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:

- (a) the Covered Person’s life could be in serious jeopardy;
- (b) bodily functions would be seriously impaired; or
- (c) a body organ or part would be seriously damaged; or
- (d) serious disfigurement; or
- (e) serious jeopardy to the health of the fetus.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

“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, or 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 of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating

facility or other facility studying substantially the same drug, device, medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

“Hospital” means a facility which meets all of these tests:

- (a) it provides in-patient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it is run as a Hospital under the laws of the jurisdiction which it is located; and
- (f) is accredited by the Joint Commission of Accreditation of Healthcare.

Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for Mental or Nervous Disorders; or substance abuse. The term “Hospital” includes (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax supported institutions which are not required to maintain surgical facilities.

“Immediate Family Member(s)” means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

“Injury” means bodily injury due to an Accident which: (a) results, directly and independently of sickness, disease, or bodily infirmity; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force.

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

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

A service or supply will not be considered as Medically Necessary if:

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

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

“Pre-Existing Condition” means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 6 months prior to the Covered Person’s effective date of coverage under the Policy or a pregnancy existing on the Covered Person’s effective date of Coverage under the Policy. Treatment includes but is not limited to prescription drugs.

“Reasonable and Customary” means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person’s coverage. Sickness also includes pregnancy and complications of pregnancy.

All Sicknesses due to the same or a related cause are considered one Sickness.

Non-Duplication of Coverage—The Policy

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

Policy Year

The Policy is rated on a single Policy year basis. Any deductible, out-of-pocket maximum and/or co-insurance will not be carried forward.

Continuously Insured

Continuously insured means a person has been continuously insured under the Policy and prior Student Health Insurance policies issued to the University. 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 Policy. Previously insured dependents and students must re-enroll for coverage in order to avoid a break in coverage within 30 days of the end of the prior coverage for conditions which existed in prior Policy years. Once a break in continuous insurance occurs, the definition of Pre-Existing Condition will apply in determining coverage of any condition which existed during such break.

Subrogation

If the Company has paid benefits to the Covered Person for Injuries received in a covered Accident, and in their opinion a third party might 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 group or group-type 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.

Extension of Benefits

If a Covered Person is Hospital confined on the date his or her insurance ends, the term Eligible Expenses includes charges incurred after the date such insurance ends. Eligible Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 31 days after the date such insurance ends or until discharged from the Hospital, whichever is earlier, subject to any maximum amounts stated in the Policy.

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

Coverage for Students on University-Approved Leave of Absence

A Covered Student, and his or her Covered Dependents, is eligible for a leave of absence when approved by the Policyholder (RFUMS). During the approved leave, coverage may continue until the earlier of: (1) the date the approved leave ends; (2) the end of the period for which premium has been paid. In no event will the approved leave extend beyond a total of 12 months during a Covered Student's attendance at RFUMS.

Continuation Privilege After Termination

If the Covered Student (and Covered Dependents) becomes ineligible under this plan by graduating, he or she is eligible for up to 6 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 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. A Continuation Plan will not be available to any Covered Person who has met the Maximum Policy Benefit under the Student Health Plan. Continuation of Coverage will be subject to the terms of the Policy. Contact Maksin Management Corp at 1-877-775-5430 for assistance.

Certificate of Creditable Coverage

Coverage under this health plan is "creditable coverage" under Federal Law. When the Covered Person's coverage terminates, he or she can request a Certificate of Creditable Coverage, which is evidence of his or her 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 his or her 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 2647, Camden, NJ 08101-2647. Or you may call toll free at 1-877-775-5430.

SCHEDULE OF BENEFITS

The Plan Pays Eligible Expenses at Applicable Co-Insurance Percentage After the Deductible

ELIGIBLE MEDICAL SERVICES INCLUDE:	PLAN A	PLAN B
Maximum per Policy Year	\$200,000 Per Injury or Sickness	\$200,000 per Injury or Sickness
Deductible per Policy Year (In-network and non-network deductible apply separately)	In-Network: \$500 per person / \$1,500 per family Non-Network: \$1,000 per person / \$3,000 per family	In-Network: \$750 per person / \$2,240 per family Non-Network: \$1,500 per person / \$4,500 per family
Co-Insurance per Policy Year (in-network and non-network co-insurance apply separately)	90% in-network (PPO Allowable Charges) 60% non-network (Reasonable and Customary)	80% in-network (PPO Allowable Charges) 50% non-network (Reasonable and Customary)
Out-of-Pocket Maximum per Policy Year (excludes deductible and co-payments) (in-network and non-network maximums apply separately)	In-Network: \$1,000 per person / \$3,000 per family Non-Network: \$3,000 per person / \$9,000 per family	In-Network: \$2,000 per person / \$6,000 per family Non-Network: \$4,000 per person / \$12,000 per family
INPATIENT SERVICES		
Room and Board Expense (average daily semi-private room rate; general nursing care provided by the Hospital)	90% in-network / 60% non-network	80% in-network / 50% non-network
Intensive Care	90% in-network / 60% non-network	80% in-network / 50% non-network
Hospital Miscellaneous including the cost of the operating room, laboratory tests and x-ray examinations including professional fees, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies.	90% in-network / 60% non-network	80% in-network / 50% non-network
Surgical Services (Doctor's Charges)	90% in-network / 60% non-network	80% in-network / 50% non-network
Assistant Surgeon	90% in-network / 60% non-network	80% in-network / 50% non-network
Anesthesia , professional services	90% in-network / 60% non-network	80% in-network / 50% non-network
Registered Nurse (Private Duty Nursing Care)	90% in-network / 60% non-network	80% in-network / 50% non-network
Doctor's Visits	90% in-network / 60% non-network	80% in-network / 50% non-network
Psychotherapy	90% in-network / 60% non-network	80% in-network / 50% non-network
Physiotherapy	90% in-network / 60% non-network	80% in-network / 50% non-network
Newborn Nursery Care (Nursery Charges Only)	90% in-network / 60% non-network	80% in-network / 50% non-network
OUTPATIENT SERVICES		
Surgical Services (Doctor's Charges)	90% in-network / 60% non-network	80% in-network / 50% non-network
Anesthesia , professional services	90% in-network / 60% non-network	80% in-network / 50% non-network
Day Surgery Miscellaneous* (Facility Charges) related to scheduled surgery including the cost of the operating room, laboratory tests and x-ray examinations including professional fees, anesthesia, drugs (excluding take-home drugs) or medicines, and supplies.	90% in-network / 60% non-network	80% in-network / 50% non-network
Doctor's Office Visits (not subject to deductible or co-insurance) Limited to one (1) visit per day and does not apply when related to surgery	\$30 Co-Payment Per Visit	\$30 Co-Payment Per Visit
Routine Wellness Exam and Labs up to a combined maximum benefit of \$250 per Policy Year Includes • Doctor's Office Visit (not subject to deductible or co-insurance) Limited to one (1) exam per Policy Year • Routine Labs (not subject to deductible)	100% of Eligible Expenses after \$30 Co-Payment 90% in-network/60% non-network	100% of Eligible Expenses after \$30 Co-Payment 80% in-network/50% non-network
Routine Gynecological Exam and PAP Test (not subject to deductible or co-insurance) Limited to one (1) exam per Policy Year	\$30 Co-Payment	\$30 Co-Payment
Physiotherapy	90% in-network / 60% non-network	80% in-network / 50% non-network
Medical Emergency (use of Emergency Room & Supplies)	90% in-network / 60% non-network	80% in-network / 50% non-network
X-Ray and Laboratory	90% in-network / 60% non-network	80% in-network / 50% non-network
Radiation Therapy	90% in-network / 60% non-network	80% in-network / 50% non-network
Tests and Procedures: diagnostic services and medical procedures performed by the Doctor, other than Doctor's visits, physiotherapy, x-rays and lab procedures.	90% in-network / 60% non-network	80% in-network / 50% non-network
Injections (when administered in a Doctor's Office)	90% in-network / 60% non-network	80% in-network / 50% non-network
Chemotherapy	90% in-network / 60% non-network	80% in-network / 50% non-network
Psychotherapy	90% in-network / 60% non-network	80% in-network / 50% non-network
CAT Scan/MRI	90% in-network / 60% non-network	80% in-network / 50% non-network
Alcohol / Substance Abuse	90% in-network / 60% non-network	80% in-network / 50% non-network
OTHER SERVICES		
Ambulance	90% of Eligible Expenses	80% of Eligible Expenses
Braces & Appliances / Durable Medical Equipment (only upon a Doctor's written prescription)	90% in-network / 60% non-network	80% in-network / 50% non-network
Consultant Fee Expense (when ordered by the attending Doctor to confirm diagnosis or determine diagnosis)	90% in-network / 60% non-network	80% in-network / 50% non-network
Elective Abortion	90% in-network / 60% non-network	80% in-network / 50% non-network
Dental (injury to sound natural teeth or extraction of impacted wisdom teeth or for treatment of dental abscess or secondary infection due to dental abscess)	90% of Eligible Expenses	80% of Eligible Expenses
Outpatient Prescription Benefit – Refer to Pharmacy Network Section on Page 5.		

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 or for treatment of dental abscess or secondary infection due to dental abscess.
2. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such except for aphakic patients (including lenses required after cataract surgery and soft lenses or sclera shells to treat Sickness or Injury); radial keratotomy or laser surgery; orthodontic braces and orthodontic appliances or prescriptions or examinations for such.
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. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline maintaining regular published schedules on a regularly established route.
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 cosmetic surgery except that "cosmetic surgery" shall 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 newborn child which has resulted in a functional defect. It also shall not include breast reconstruction after a mastectomy.

9. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, illegal occupation, insurrection or civil commotion.
10. for Elective Treatment or elective surgery, except as specifically provided in the Policy.
11. for any services rendered by a Covered Person's Immediate Family Member.
12. for a treatment, service or supply which is not Medically Necessary.
13. for surgery and/or treatment of acne; acupuncture; gynecomastia; allergy, including allergy testing and anti-toxins; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions; deviated nasal septum, including sub-mucous resection and/or other surgical correction thereof except for purulent sinusitis or unless due to Injury occurring while coverage is in force; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; learning disabilities; Attention Deficit Disorder; nonmalignant warts, moles and lesions unless Medically Necessary; obesity and any condition resulting therefrom (including hernia of any kind, heart disease); premarital examinations; sexual reassignment surgery and related therapy; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including supplies, treatment and testing thereof; preventive medicines or vaccines, except where required for the treatment of Injury; smoking cessation; tubal ligation; vasectomy; actinic or seborrheic keratosis; dermatofibrosis; nevus of any description or form; halus valgus repair; hernia of any kind; varicosity; hyperhidrosis; alopecia; and weight reduction.
14. in connection with birth control, except prescription contraceptives; sterilization or sterilization reversal, including surgical procedures and devices;
15. as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place, except in a Driver's Education Program. This exclusion will not apply to passengers if they are Covered Persons under this Policy.
16. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two- or three-wheeled vehicle and/or off-road four wheeled motorized vehicles), personal watercraft or bungee jumping.

17. 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.
18. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, club, professional and semi-professional sports activity, including travel to and from the activity and practice; sporting events; racing or speed contests; skin diving; scuba diving; hang gliding; parasailing; sky diving; boating; sky diving; flight in an ultra light aircraft; glider flying; sail planing; parachuting; ballooning; or mountaineering (where ropes or guides are customarily used).
19. for preventive treatment, testing, medicines, serums, vaccines, or vitamins except as specifically provided in the Policy.
20. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
21. for routine physical examinations except as specifically provided in the Policy.

Pre-Existing Condition Limitation

Pre-existing Conditions are not covered for the first 6 months following a Covered Person's effective date of coverage under the Policy. This limitation will not apply if:

- (1) 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
- (2) (a) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under this 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 (b) who is not eligible for coverage under Medicare or Medicaid; and (c) who does not have other health insurance.

Creditable Coverage means coverage of the individual 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 insur-

ance, 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.

* A public health plan is defined as any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

Primary Coordination of Benefits

If a Covered Person incurs Eligible Expenses for any of the services on the Schedule of Benefits, the Company will pay the first \$100 of applicable benefits, subject to the deductible amount and benefit percentages (if any). After the Policy has paid the first \$100 of Eligible Expenses, the Policy will coordinate benefits with any valid and collectible insurance or plan as described in the Policy.

Mandated Benefits

Illinois mandates coverage for the following benefits: Initial prosthetic device and reconstructive surgery incident to mastectomy; breast implant removal; bone mass measurement; dental anesthesia; child health supervision; pre-natal HIV testing; mammographs at certain intervals; treatment of alcoholism while hospital confined; annual pap smear; prostate specific antigen tests; diabetes equipment, supplies and outpatient self-management training; colorectal cancer screening; and treatment of serious mental illness. Please see the policy on file with the policyholder for complete details. The Policy covers any other applicable mandated benefits as required by the State of Illinois.

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 was not reasonably possible to contact Travel Assist in advance.

Please refer to 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 AND STUDENT ASSIST SERVICES

Procedures on How to Access Travel Assist's 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 1-713-974-3422.

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 Assist 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 Services when you call:

- Advise Travel Assist who you are insured by.
- Provide your Policy number or school name.
- 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 needs 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 "9710543" and the password is "security".

For more informative details visit Rosalind Franklin University's personalized web page at www.maksin.com/rfums.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 Doctors or facilities if the form includes the name of the Covered Person, Covered Student's school name, 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.

A Company claim form may be secured by logging onto to www.maksin.com/RFUMS.aspx. Complete and sign the claim form and mail with itemized hospital and/or medical bills to the Claim Office at the following address:

Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647

Only one claim form is required per condition. After filing the initial claim form, additional bills may be forwarded with name, identification number, and school name/policy number.

Need help? Visit the Maksin website at:
www.maksin.com/RFUMS.aspx
for the following services:

- [Preferred Provider \(PPO\) Link](#)
- [Pharmacy Network Link](#)
- [Download Forms](#)
- [Download Brochure](#)
- [Check Eligibility Status](#)
- [Print ID Card](#)
- [Check Claim Status](#)
- [Submit a Question to our Customer Service Department](#)

Questions regarding benefits, eligibility, claims procedures or claims status should be directed to:

Claims Administrator:
Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647

Toll Free Telephone: 1-877-775-5430

Questions regarding enrollment and payment or waiver should be directed to:

Rosalind Franklin University
Business Office
3333 Green Bay Road
North Chicago, IL 60064

At Maksin Management Corp, 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/RFUMS.aspx.

Non-Renewable One-Year Term Insurance

The insurance is a non-renewable one-year term insurance. Similar coverage may be purchased for the following academic year. It is the Covered Person'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.

This is a brief description of the coverage available under policy series S30494NUFIC-IL. The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this document and the Policy, the Policy shall govern.

