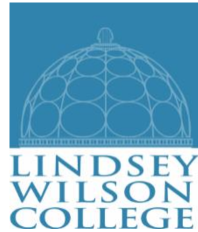
Lindsey Wilson College
Student Health Plan



Effective August 1, 2016 To August 1, 2017

CLAIMS ADMINISTRATOR

ARC ADMINISTRATORS
P.O. Box 12290
Lexington, Kentucky 40582 (877) 309-2955

CLAIM PROCEDURE

Students should obtain treatment from the Blue Raider Sports Medicine first. If the Blue Raider Sports Medicine office is closed, or if you believe it is an emergency, students should obtain treatment from the nearest Physician or Hospital.

All hospital and medical bills must be submitted for payment to the plan's Claims Administrator within 90 days after the first date of treatment. Failure to furnish this information within the 90-day period shall not invalidate nor reduce the insured's claim if it was not reasonably possible to file the claim within this time, provided that the claim is submitted as soon as is reasonably possible. In no event, except in the absence of legal capacity, will a claim be honored later than one (1) year from the date of last medical treatment.

PROVIDER NETWORKS

The Plan has contracted with HealthLink and MultiPlan as the medical Preferred Provider Organizations (PPO) for its participants. Charges at participating providers are greatly reduced

www.healthlink.com

www.multiplan.com

DESCRIPTION

This brochure provides a brief description of the important features of the Student Health Plan. It is not a policy. Terms and conditions of the coverage are set forth in the Plan Document. All covered persons will be notified of any material changes to the Plan. Please retain this brochure for reference.

EFFECTIVE DATE OF COVERAGE

The Student Health Plan becomes effective August 1, 2016 and individual student coverage is provided during the period for which the applicable premium for the student has been paid. Coverage under the Plan terminates at 12:01 a.m. on August 1, 2017.

COVERAGE

The Student Health Plan is a self-funded plan sponsored by Lindsey Wilson College and is administered by ARC Administrators. All claims will be paid by ARC Administrators as outlined in the Plan Document. The Plan covers expenses incurred for accidental bodily injury and illness as outlined in the Plan Document. A summary of benefits is included in this brochure.

IMPORTANT NOTICE

Students should obtain treatment from the Blue Raider Sports Medicine first. If the Blue Raider Sports believe it is an emergency, students should obtain treatment from the nearest Physician or Hospital.

Blue Raider Sports Medicine

Office Phone: 270-384-8238 • Fax: 270-384-8239

Office Hours: Mon-Fri 7:30 a.m. – 4:30 p.m.

Nurse Phone: 270-384-8138

Nurse Hours: Tues, Wed, Thurs 8:00 a.m. – 12:00 p.m.

ELIGIBILITY

All registered, main campus students taking a minimum of six (6) credit hours are automatically enrolled in the plan at registration, unless evidence of primary medical insurance is provided to the College before the Waiver Deadline Date, September 10, 2016. Eligible students who waive coverage under this plan may elect to enroll later if they involuntarily lose their prior insurance coverage due to no fault of their own.

Students must actively attend classes for at least the first 31 days from their effective date of coverage. Home study, correspondence and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes. Any student who does not attend classes during the first 31 days will not be covered under the Policy and a full refund of premium will be made.

Covered Students may also enroll their eligible dependents in the plan. An eligible

dependent is the Covered Student's: 1) spouse residing with the Covered Student; or 2) unmarried children under the age of 19 years (25 if a full-time student at an accredited school.)

A newly acquired dependent child will be covered under the Plan for the first 31 days after: 1) birth of a newly born child; or the earlier of 2) the effective date of adoption. Coverage for such child will be for Sickness or Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and necessary nursery care.

The Covered Student will have the right to continue such coverage for the child beyond 31 days. To continue the coverage the Covered Student must, within 31 days after the birth, adoption or placement for adoption: 1) notify the Plan in writing; and 2) pay the required additional premium for the continued coverage. If the Covered Student does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth, adoption or placement for adoption.

The Plan maintains its right to investigate student status and attendance records to verify that the Plan eligibility requirements have been and continue to be met. If and whenever the Plan discovers that the Plan eligibility requirements have not been or are not being met, its only obligation is to refund the premium less any claims paid.

ENROLLMENT

All eligible students who have not waived coverage by the Waiver Deadline Date will be automatically enrolled in the plan at the beginning of the school year. The cost of the coverage is charged to the student account at registration. Students who wish to waive coverage under the plan must submit a waiver form and proof of insurance to the College by the Waiver Deadline Date. If an eligible student waives out of the plan and later involuntarily loses his or her qualifying prior coverage, the student should notify the school to be enrolled in this plan. Students enrolling as new or transfer students in the Spring Term will also be enrolled automatically through the school, unless a waiver form and proof of insurance are submitted to the College by the Waiver Deadline Date. Eligible Students must pay the entire premium for the term in which they are enrolling.

Eligible Dependents may enroll by completing the attached enrollment form and remitting the appropriate premium by the Enrollment Deadline Date. Newly acquired dependents (spouse and/ or children) are not subject to the Enrollment Deadline Dates. However, the enrollment form and full premium payment for all newly acquired dependents (spouse and/or children) must be postmarked within 31 days of the attainment of such dependents. Failure of the student to enroll for dependent coverage within the 31 day enrollment period shall be construed as rejection of coverage. Otherwise, enrollment forms and premiums cannot be accepted after the Enrollment Deadline Date listed.

Dependents must be enrolled for the same term of coverage for which the insured student is enrolled. Coverage for eligible dependents will not be effective prior to that insured student or extend beyond that of the insured student, except as provided under the Extension of Benefits.

COST OF COVERAGE

COVERAGE TIER	ANNUAL	SPRING
Student	$285.00	$190.00
Spouse	$1,090.00	$665.00
Each Child	$785.00	$475.00

Eligibility requirements must be met each time premium is paid to continue coverage. The above student rates include a school administrative fee.

REFUNDS

No premium refunds are permitted, except as specifically stated in the Policy for a student who does not attend classes for the first 31 days or when an Insured enters full-time active military service, at which time a pro rata refund of premium paid will be made upon written request.

TERMS OF COVERAGE

The policy becomes effective at 12:01 a.m. on August 1, 2016. Coverage for eligible students will become effective at 12:01 a.m. on August 1, 2016 unless a waiver form and proof of insurance are submitted by the Waiver Deadline Date.

Coverage for new students, as well as coverage for students who have previously waived cover- age and are enrolling due to an involuntary loss of coverage will become effective at 12:01 a.m. on the latest of: 1) the effective date of the term for which premium has been paid; or 2) the day immediately following the date on which the student is enrolled and premium has been paid.

Coverage for Eligible Dependents becomes effective at 12:01 a.m. on the first date of the applicable term if the enrollment form and premium are postmarked on or after the first date of the applicable plan term, coverage will be effective at 12:01 a.m. on the date immediately following the date on which the enrollment form and premium are postmarked.

Coverage terminates at 12:01 a.m. on the earliest of the following dates:

1. The date the Policy terminates for all insured persons;
2. The last day of the Term of Coverage for which premium is paid;
3. The date an insured person ceases to be eligible for the insurance; or
4. The date an Insured Person enters Military Service.

Term	Effective Date	Termination Date	Student Waiver Deadline	Dependent Enrollment Deadline
Annual	8/1/2016	8/1/2017	9/10/2016	9/10/2016
Spring*	1/12/2017	8/1/2017	2/7/2017	2/7/2017

*Only students new for the Spring or students who have waived in the Fall but then had an involuntary Loss of Coverage may enroll in the Spring Term.

There is no continuous coverage for this plan for students and/or dependents who are no longer eligible.

We do not send termination notices. It is the Insured's responsibility to initiate coverage in a timely manner, subject to continuing eligibility.

EXCESS PROVISION

Even if you have other insurance, the Plan may cover unpaid balances, deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for injury or sickness which is paid or payable by Other Medical insurance.

We will not duplicate benefits for expenses covered by any Other Valid and Collectible medical, health or accident insurance or prepayment plan. Our liability for benefits payable due to expenses incurred will be limited to the part of the expenses, if any, that is in excess of the total benefits payable by Other Valid and Collectible insurance on an expense incurred or provision of service basis. Benefits payable under the Plan will be excess and secondary to such other coverage.

EXTENSION OF BENEFITS

The coverage provided under the Plan ceases on the termination date, except under the following conditions:

1. If the Covered Person is receiving treatment for a Sickness or Injury on the date his or her coverage terminates as a result of Sickness or Injury for which benefits were payable prior to the date his or her coverage terminated, benefits will be payable for the Covered Charges incurred until the earliest of: a) the end of the Sickness or Injury; b) the end of the 90-day period following the date his or her coverage terminated; or c) the date the applicable maximum amount is reached; or
2. If the Covered Person is Hospital Confined on the date the Plan terminates, we will extend that Insured's benefits. Benefits will be paid as if coverage had remained in effect. This Extension of Benefits will end at the earlier of: a) the date continuous Hospital Confinement ends; b) the end of a 12 month period following the date the

Plan terminates; or c) or the date the applicable maximum amount is reached.

3. If the Covered Person is Totally Disabled on the date his or her coverage terminates, benefits will be payable for the Covered Charges incurred until the earliest of: a) the end of Total Disability; b) the end of the 12-month period following the date his or her coverage terminated; or c) the date the applicable maximum is reached.

Total Disability/Totally Disabled means, with respect to the Covered Person, the inability to attend classes at the location where he is enrolled. With respect to a Dependent, or the Covered Person 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.

The total payments made in respect to the Covered Person for such condition both before and after the termination date will never exceed the maximum benefit. After the Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made. This Extension of Benefits provision is applicable only to the extent the Covered Person will not be covered under this or any other health insurance policy in the ensuing term of coverage.

DEFINITIONS

Covered Charge: The Reasonable and Customary Charge incurred for a 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 Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

Doctor: A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and is not a Family Member.

Hospital: An institution licensed, accredited or certified by the State which: Is accredited by the Joint Commission on Accreditation of Healthcare Organizations; Provides 24-hour nursing service by licensed registered nurses (R.N.); Mainly provides diagnostic and therapeutic care under the supervision of Doctors while Hospital Confined; and Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering treatment or services for Mental or Nervous Disorders; or an institution mainly rendering treatment or services for substance abuse, except as specifically provided in the Policy.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 18 consecutive hours for which a room and board charge is made by reason of a Sickness or Injury for which benefits are payable

Injury: Bodily injury due to an Accident which results solely, directly and independently

of disease, bodily infirmity or any other causes. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries are considered a single injury.

Other Medical Insurance: Any reimbursement for or recovery of any element of Covered Charges incurred available from any other source whatsoever, except gifts and donations, but including without limitation: Any individual, group, blanket, or franchise policy of accident, disability or health insurance; any arrangement of benefits for members of a group, whether insured or uninsured; any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations; any amount payable for hospital, medical or other health services for accidental bodily injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy; any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his rights to recover future medical expenses that would have been payable except for that settlement; Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he becomes disabled while insured hereunder; any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Pre-existing Condition: 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 Plan or a pregnancy existing on the Covered Person's effective date of cover- age under the Plan.

Reasonable and Customary Charges, Fees or Expenses: An amount equal to the lesser of: The actual amount charged by the provider; the negotiated rate, if any; or the reasonable charge as determined by the Payment System software as shown in the Schedule.

Sickness: Illness, disease, and Complications of Pregnancy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. Sickness will also include normal pregnancy.

PRE-EXISTING CONDITION LIMITATION

Pre-existing conditions are not covered for the first six months following a Covered Person's Effective Date of coverage under the Plan. The limitation will not apply if: The Covered Person has been continuously covered under this Plan for more than 12 months. By being "Continuously Covered" means a person has been continuously

covered under this Plan and prior student health insurance policies issued to the Policyholder. Persons who have remained continuously covered will be covered for Sickness or Injury which was payable while continuously covered except for expenses payable under prior policies or in the absence of this Plan. Previously enrolled persons must reenroll for coverage within 30 days of the end of the prior coverage in order to avoid a break in coverage for Sickness or Injury which existed in prior coverage periods. Once a break in continuous coverage occurs, the definition of Sickness or Injury will apply in determining coverage for any Sickness or Injury which existed during such break. Or the individual seeking coverage under the Plan has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under the Plan within 63 days of termination of prior Creditable Coverage. The Plan will credit the time the individual was covered under prior Creditable Coverage.

CERTIFICATE OF QUALIFYING HEALTH PLAN COVERAGE

If a Covered Person is no longer eligible to be covered under the Plan, the Covered Person should request a Certification of Qualifying Health Plan Coverage from ARC Administrators.
This request can be made by phone or in writing. This request must include the name of the school and the name of each person who is no longer eligible to be insured under the plan.

EXCLUSIONS

- Treatment, services or supplies which are not medically necessary; are not prescribed by a doctor as necessary to treat an illness or injury; are determined to experimental or investigational in nature by the Plan; are received without charge or legal obligation to pay; would not routinely be paid in the absence of insurance; are received from any family member.
- Services that are provided normally without charge by the Student Health Center; services for fees provided by the Plan Sponsor; or services rendered by any person employed by the Plan Sponsor, including team doctor and trainers, or any other service provided at no cost.
- War or any act of war, declared or undeclared, or while in the armed forces of any country.
- Injuries caused by, or resulting from, the use of alcohol, controlled substance, illegal drugs, or any other drugs or medicines that are not taken in the dosage or for the purpose prescribed by the person’s doctor.
- Intentionally self-inflicted injury, suicide or any attempt of such.
- Any loss covered by state or federal worker’s compensation law, employer’s

liability law, occupational disease law, or similar laws or acts.

- Cosmetic surgery other than reconstructive surgery incidental to or following surgery from trauma, infection or other diseases of the involved part, or reconstructive surgery because of a congenital disease or anomaly as provided for dependent newborns.
- 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.
- Participation in a riot or civil disorder, commission of or attempt to commit a felony, or fighting, except in self-defense.
- Surgery and/or treatment for acne, allergy, including allergy testing, nonmalignant warts, moles and lesions, unless medically necessary; hair growth or removal; sleep disorders, including testing thereof and weight reduction.
- Reproductive/Infertility services including, but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures.
- Dental treatment, except as specifically provided for by the Plan.
- Normal health checkups, preventive testing or treatment, screening exams or testing in the absence of injury.
- Eye examinations, prescriptions or the fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, unless payable as a Covered Expense associated with an illness or injury covered by the Plan.
- All forms of abortion and charges related thereto, unless it is an involuntary and medically unassisted act or deemed medically necessary by a doctor with the sole criteria that the mother’s life is in immediate danger.
- Injury of any Covered Student sustained while: participating in any school, professional or organized sports contest or competition, traveling to or from such sport, contest or competition, during participation in any practice or conditioning program for such sport, contest or competition unless specifically provided for by the Plan.
- Travel in or upon a snowmobile; any two-or-three wheeled vehicle; or any off-road motorized vehicle not requiring licensing as a motor vehicle; bungee jumping, skydiving, parasailing or paragliding.

CLAIM APPEAL

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), a Covered Person who disagrees with how a claim was processed may appeal that decision.

The Covered Person must request an appeal in writing within 60 days of the date appearing on the EOB. The appeal request must include why they disagree with the way the claim was processed. The request must include any additional information they feel supports their request for appeal, e.g. medical records, physician records, etc.

Please submit all appeal requests to:

ARC ADMINISTRATORS
P.O. Box 12290
Lexington, Kentucky 40582
(877) 309-2955