

24-HOUR NURSE HELPLINE PLAN

The 24-Hour Nurse Helpline is designed to help members become more informed about their healthcare. The Nurse Helpline is a 24/7 confidential telephone service that allows members to ask questions and receive information about their health, illnesses and medications. There is no cost to use the Helpline.

Members have unlimited access to registered nurses via a toll-free number 24 hours a day, 365 days a year. These nurses are specially trained to offer prompt, confidential medical counseling to help members make informed decisions about their health and the medical care they receive. However, our nurses do not diagnose or provide treatment.

SERVICES INCLUDE

1. Toll-free, confidential availability to registered nurses 24 hours a day at **1-800-982-2401**.
2. Guidance and information for dealing with common ailments.
3. Explanations on what to expect during medical tests.
4. Help from a registered nurse who can answer questions regarding:
 - Diagnostic and surgical procedures
 - Recently diagnosed medical conditions
 - Prescription and over-the-counter medication information

The 24-Hour Nurse Helpline Plan is not insurance

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Treatment, services or supplies which: are not medically necessary; are not prescribed by a doctor as necessary to treat a Sickness or Injury; are determined to be experimental/investigational in nature by the Company; 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.
2. Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
3. Injury or Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or Law.
4. 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 commercially-scheduled airline.
5. Cosmetic surgery, except made necessary by Injury or medically diagnosed congenital defects and birth abnormalities of a Dependent newborn infant.
6. Surgery and/or treatment for: acne; acupuncture; allergy, including allergy testing; biofeedback-type services; breast implants or breast reduction; circumcision; corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof; family planning; fertility tests: impotence, organic or otherwise; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind); premarital examinations; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, sleep disorders, including testing thereof; tubal ligation; vasectomy; and weight reduction.
7. Temporomandibular Joint Dysfunction (TMJ).
8. Expenses incurred as a result of dental treatment, except as specifically stated.
9. Expenses for preventative medicines, serums or vaccines, except where required for the treatment of Injury.
10. Treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted conception.
11. Organ, tissue and cell transplants.
12. Injury resulting from skydiving, parachuting, hang gliding, or parasailing.
13. Services that are provided normally without charge by the Policyholder's student health center, services for fees provided by the Policyholder, or services rendered by any person employed by the Policyholder, including team Doctor and trainers, or any other service performed at no cost.
14. Routine physical examinations and routine testing; preventive testing or treatment; and screening exams.
15. Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; or other 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.
16. Routine newborn infant care, well-baby care and related Doctor charges, except as specifically provided for in the Policy.
17. Outpatient Prescription Drugs, except as specifically stated.
18. Braces and appliances.
19. Treatment of hernia of any kind.
20. Injury resulting from the practicing for, participating in, or the traveling as a team member to and from, interscholastic, intercollegiate, professional or semi-professional sports, except as specifically stated.

DEFINITIONS

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 once accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

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.

Pre-Existing Conditions: 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 or coverage under the Policy.

Reasonable and Customary Charges: means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgement of the Company are in excess of Reasonable and Customary Charges.

CLAIM PROCEDURE

Secure a claim form from the Wellness Center or from the agent, fill in the necessary information, attach all itemized doctor and hospital bills and send to:

National Guardian Life Insurance Company
c/o First Agency, Inc.
5071 West H Ave.
Kalamazoo, MI 49009-8501
www.1stagency.com

Proof of loss must be submitted to the address above within 90 days from the date of Injury or Sickness.

In the event it becomes necessary to check on the status of your filed claim, you may call the Claims Office from 7:30 a.m. to 4:30 p.m. (Eastern Standard Time), Monday through Friday. The telephone number is: 269-381-6630.

No premium refunds are permitted except when the student enters full time active military service in which case a pro-rata refund will be made upon request.

This is a non-renewable one year term policy. It is the insured's responsibility to maintain continuity of coverage. No renewal notice will be sent to the Insured.

Keep this brochure as summary of the Insurance. No individual policies will be issued. If any discrepancies exist between the brochure and the policy, the policy on file with the school governs the payment.

If your coverage ends after this plan and you obtain other coverage, student insurance qualifies as prior creditable coverage. A certification of coverage will be furnished upon written request to the company.

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

For Students Attending

OLIVET COLLEGE

August 1, 2011
to
August 1, 2012

Administered by

First Agency, Inc.
5071 West H Ave.
Kalamazoo, MI 49009-8501
(269) 381-6630

Underwritten by

National Guardian Life Insurance Company

Please read this brochure carefully

Dear Student:

Olivet College is offering a student accident and sickness insurance program on a blanket basis. The College has selected a plan that will provide this coverage automatically for all full-time students enrolled in twelve or more credit hours per semester. The Coverage is underwritten by the National Guardian Life Insurance Company, Madison, WI.

We are hopeful that every student will take advantage of this program. Your participation will help relieve some of the financial burden resulting from unexpected medical expenses in the event of Injury or Sickness. **Note: Your current insurance plan may not include providers in areas surrounding Olivet College. Please check with your insurance company regarding medical providers and coverage in surrounding areas. You may incur out-of-pocket expenses if your current plan is not accepted by area doctors.** Because of the very low cost of this plan you may wish to carry it in addition to any coverage you may now have.

All registered full-time students at Olivet College will automatically be included in this program. **The \$664 annual premium is added to your registration fees, UNLESS THE PARENT, GUARDIAN OR STUDENT SPECIFICALLY REQUESTS EXCLUSION BY RETURNING THE WAIVER STATEMENT ALONG WITH A COPY OF THEIR INSURANCE CARD TO OLIVET COLLEGE'S WELLNESS CENTER BEFORE OCTOBER 1ST, 2011.**

The Company maintains the right to investigate student status and attendance records to verify that Policy eligibility requirements have been met. If the Company discovers that the Policy eligibility requirements have not been met, the Company's only obligation is a refund of premium. Eligibility requirements must be met each time a premium is paid to continue coverage.

This brochure outlines the scope of coverage and benefits and should be retained for future reference. If you have any questions about the actual policy details, please contact the Wellness Center or the Plan Administrator. The Policy shall control in the event of any discrepancy between the Policy and this brochure.

Students who enroll may secure coverage for eligible Dependents. Eligible Dependents are the Insured's spouse who resides with the Insured and the Insured's child who is dependent upon the Insured for support and maintenance and is under the age of 23.

Open enrollment is only allowed during the open enrollment period which is August 30, 2011 to October 1, 2011. Exceptions will be made for the following:

- Adding a new spouse or dependent child within 31 days of marriage, birth or adoption;
- Enrolling as a new or transfer student within 31 days of enrollment at the school; and
- Within 31 days of ineligibility under another plan of creditable coverage provided COBRA continuation of coverage was accepted and exhausted, if offered.

Newborn children are covered for Injury or Sickness from birth until 31 days old. Coverage may be continued for that child when we are notified in writing within 31 days from the date of birth and required premium is paid.

Notice of Privacy Practices For Protected Health Information: You have the right to adequate notice of the use and disclosure of protected health information that may be made by us, and of your rights and our legal duties with respect to protected health information. You have the right to request this notice in writing once every 3 years starting from the date of your initial enrollment at the school by writing to: First Agency, Inc., 5071 West H Avenue, Kalamazoo, MI 49009-8501.

MEDICAL BENEFITS SCHEDULE

When a Covered Person's covered Injury or Sickness requires treatment by a doctor, the Policy will provide the following benefits while the Covered Person's coverage is in force during the Policy year for the Reasonable and Customary (R&C) charges scheduled below. Treatment of Injury must begin within 30 days of covered accident. The Policy will allow benefits only for expenses not covered by other valid and collectible coverage. If the total covered expenses are less than \$100, this provision will be waived.

PART A: BASIC INJURY BENEFITS \$5,000 maximum/each Injury, subject to following limits	
OUTPATIENT PRESCRIPTION DRUGS (\$10 co-pay generic/\$25 co-pay brand name).....	\$100
INTERCOLLEGIATE SPORTS INJURY.....	R & C up to \$2,500
DENTAL TREATMENT - Repair and/or replacement of sound and natural teeth.....	\$500
PHYSICAL THERAPIST.....	\$25 a visit, one visit/day
PART B: BASIC SICKNESS BENEFITS* \$5,000 maximum/each Sickness, subject to following limits	
HOSPITAL, ROOM AND BOARD: Average daily semiprivate room rate.....	\$350/day
HOSPITAL MISCELLANEOUS INPATIENT: for X-ray examination, laboratory tests, anesthesia, operating room, medications, dressings, etc.....	\$1,500
HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS - in lieu of INPATIENT.....	\$5,000
DOCTOR'S NONSURGICAL VISITS (Inpatient).....	\$30/visit, 1 visit/day, up to 30 visits
DOCTOR'S NONSURGICAL VISITS (Outpatient).....	\$30/visit, 1 visit/day, limit 5 visits
SURGICAL TREATMENT: (in or out of hospital) - services performed by a licensed doctor as determined by reference to the 80th percentile and in accordance with the most current Reasonable and Customary payment system.....	80% of R&C incurred to a maximum of \$3,000
ANESTHETIST AND/OR ASSISTANT SURGEON.....	25% of Surgical Treatment
OUTPATIENT TREATMENT: when the Insured is not hospital confined as a resident bed patient and incurs expense for emergency room and/or diagnostic X-rays/lab test by doctor or hospital.....	\$1,000
ALCOHOL/DRUG ABUSE BENEFITS:.....	\$3,969 per policy year
AMBULANCE SERVICES.....	\$200
MATERNITY BENEFITS:.....	Same as any Sickness
MENTAL OR NERVOUS DISORDERS: is payable on the same basis as Sickness, except: Doctors nonsurgical visits (Inpatient).....	\$30/visit, 1 visit/day, up to 10 visits
OUTPATIENT PRESCRIPTION DRUGS (\$10 co-pay generic/\$25 co-pay brandname).....	\$100
PAP SMEARS AND STD SCREENING.....	Up to \$150 per Policy Year
*Covered Charges paid under the Basic Medical Expense Benefit of this Policy shall not be paid under the Major Medical Expense Benefit of this Policy.	
PART C: MAJOR MEDICAL BENEFITS \$50,000 maximum/each Injury and each Sickness	
After medical expenses incurred reach \$5,000 under the Basic Injury Benefit or Basic Sickness Benefit (PARTS A or B), the Company will then pay 80% of the Reasonable and Customary Expenses incurred during the Policy Year up to maximum of \$50,000. This maximum includes both benefits paid under PARTS A or B and PART C. Benefits shall end at the close of the period of coverage under this Policy. No Benefits are payable for mental or nervous disorders, motor vehicle injuries or intercollegiate sports injuries.	
PART D: MEDICAL EVACUATION AND REPATRIATION (Foreign Students and Foreign Study)	
Medical Evacuation: If the Insured person, by reason of covered Injury or Sickness and following at least 5 consecutive days of hospital confinement, requires evacuation to the Insured Student's home country, the Company will pay the expenses actually incurred for such evacuation up to a maximum of \$10,000 provided that such evacuation is certified as medically necessary by the attending Doctor and subject to prior approval by the Company.	
Repatriation: If the Insured person dies as a result of a covered Injury or Sickness, the Company will pay the expense actually incurred for the preparation and transportation of the body to the Insured Student's home country, up to a maximum of \$7,500. Payment is subject to prior approval by the Company.	
PART E: ACCIDENTAL DEATH AND DISMEMBERMENT	
Occurring within 180 days from date of accident, pays in addition one of the following (the largest applicable amount):	
Accidental Death.....	\$1,000
Single Dismemberment.....	\$1,000
Double Dismemberment.....	\$2,000
PART F: PREMIUMS	
	8/1/11 TO 8/1/12
Students only - under age 35	\$664.00
Dependents (each)	\$911.00
Students only - age 35 or over	\$787.00
Dependents (each)	\$1,700.00

PERIOD OF COVERAGE

The policy is effective August 1, 2011 to August 1, 2012. Students that sign up for coverage after the beginning date of either semester will be covered from the date of sign-up to August 1, 2012.

TERMINATION DATE

Coverage terminates at the earliest of: the termination of the Policy; the last day of the Term of Coverage for which premium is paid; the last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined; or the date a Covered Person enters full time active military service.

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 Policy for more than 12 months; or (b) The individual seeking coverage under the Policy has an aggregate of 18 months of creditable coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior creditable coverage. We will credit the time the individual was covered under the prior creditable coverage, and whose most recent prior creditable coverage was under employer group health plan; and who accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.