

Charleston Southern University



2007–2008 International Student Health Insurance Plan

This is a comprehensive medical benefit plan designed to protect international students against unforeseen medical expenses while studying outside their home countries.

All international students must have proof of insurance to register.



underwritten by
Nationwide Life Insurance Company

policy number
302-068-3905

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This brochure gives a brief description of the coverage. Full details are in the policy. A copy of the policy may be reviewed at the International Student Office. Any discrepancy between this brochure and the policy will be governed by the policy.

ATTENTION

Your ID Card is at the back of this booklet. Please detach and retain for proof of coverage. No other will be issued.

Always carry your insurance ID card with you.

Also, there is a Quick Reference Guide on the back cover. You should tear it out and keep it with you along with your ID card.

ELIGIBILITY

An international student, visiting faculty, scholar or other person with a current passport or student visa (F-1, J-1 or M-1 visa) temporarily located outside the home country who has not been granted permanent residency status while engaged in full-time educational activities through the College, is required to be insured under the policy. Contact the International Student Office for details.

Insureds must have paid the required premium and their name, student number and date of birth must have been included in the declaration made by the College or the Administrative Agent to the Insurer. Insured students must actively attend classes for at least the first 31 days from their effective date of coverage, or the entire period for which coverage is purchased, whichever is the lesser, except in the case of medical withdrawal (as verified and approved by the school).

The Company maintains its right to investigate student (and dependent) status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium less any claims paid.

Insured students may also enroll their eligible dependents. Dependents eligible to be insured under the plan are limited to the eligible student's spouse and unmarried children under 19 years of age. Eligible dependents must be enrolled on the date the student enrolls or within 31 days of birth, adoption, marriage, arrival in the U.S. or termination of other coverage. Coverage for eligible dependents will not be effective prior to that of the insured student or extend beyond that of the insured student.

If a child is born to an insured student, that child will be covered under the plan for the first 31 days after: 1) the birth date of the newly born child; 2) the effective date of adoption of the child by the student; or 3) the date of placement of the child for adoption with the student. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care.

The insured student will have the right to continue coverage for the child beyond 31 days. To continue the coverage the Insured must, within 31 days after the birth, adoption or placement for adoption: 1) submit a completed enrollment form; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the 31-day period.

TERMS OF COVERAGE

Effective Dates

Coverage begins at 12:01 a.m., if the eligibility requirements are met, on the later of: 1) the policy effective date (8/12/07); 2) the effective date reported as the term of coverage by the University or the Administrative Agent; or 3) the day immediately following the date that full premium and completed application are received by the Administrative Agent, University, or the Administrative Agent's Designee.

Termination Dates

Coverage ends at 12:01 a.m. on the earliest of: 1) the policy termination date (8/12/08); 2) the last day for which premium has been paid; 3) the date the Insured ceases to be eligible for this insurance; 4) the date the policy terminates; 5) the date the Insured enters full-time active military service.

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

We do not send termination or renewal notices. It is the Insured's responsibility to renew coverage in a timely manner, subject to continuing eligibility. Eligibility requirements must be met each time premium is paid to renew coverage.

EXTENSION OF BENEFITS

When, as result of an Injury or Sickness, an Insured incurs covered expenses upon the recommendation and approval of a licensed doctor, the Company will pay the amount of the covered medical expenses actually incurred up to 1) or 2), whichever occurs first:

- 1) The maximum dollar amount stated in the policy; or
- 2) The termination date of the policy subject to the following Extension of Benefits: If an Insured is hospitalized due to Sickness or Injury on the date of termination, benefits will continue as long as he or she is continuously hospitalized for such Sickness or Injury, up to a maximum of 13 weeks.

This Extension of Benefits provision is applicable only to the extent that the Insured will not be covered under this or any other student health insurance policy in the ensuing term of coverage. Dependents that are newly acquired during the insured student's Extension of Benefits period are not eligible for benefits under this provision.

REFUND POLICY

There are no premium refunds, except in the case the Insured returns to the home country or country of regular domicile, in which case a pro-rata refund will be issued only upon written proof from the College that the Insured is no longer eligible for coverage.

PREFERRED PROVIDER ORGANIZATION

Please read the following information so you will know from whom or what group of providers health care may be obtained.

This plan has incorporated several cost containment features that are designed to provide the best care available by providing access to a panel of medical professionals, including doctors and hospitals, known as the Preferred Provider Organization (PPO). This PPO network is available through the First Health Network. Network access provides benefits nationwide for covered charges incurred at 90% of PPO charges when treated by network providers. Benefits are provided worldwide for covered charges incurred at 70% of Reasonable and Customary (R&C) charges when treated by non-network providers.



Please be aware that the Preferred Provider Organization (PPO) for this plan has changed. Before seeking treatment, make sure that your doctor is a member of the new network or you may have to pay a higher coinsurance.

For a complete listing of the PPO hospital and Doctor facilities, call 1-800-226-5116 or access the internet website: www.myfirsthealth.com.

Please be aware that if an Insured is treated at a PPO Hospital, it does not mean that all providers at that Hospital are PPO providers. In addition, if an Insured is referred by a PPO provider to another provider or facility, it does not mean that the provider or facility to which the Insured is referred is also a PPO provider. For instance, when a network provider refers you to a lab for tests, be sure it is a network lab. Also, if you have surgery, make sure the anesthesiologist is a network provider or you will be required to pay the 30% coinsurance.

PRE-CERTIFICATION FOR HOSPITALIZATION

The treating licensed doctor must consult with the Company prior to any hospitalization. It is the Insured's or the Insured's representative's responsibility, not the attending doctor's, to contact the Utilization Review Organization. In the case of life- and/or organ-threatening situations, the consultation must take place as soon as reasonably possible. If such prior notification is not given, the Company will reduce payment for such claims by \$750 of the covered expenses. To pre-certify a hospitalization or diagnosis or treatment method, call First Health Network (FHN) at **1-800-572-5508**.

CONTINUED STAY REVIEW

The Utilization Review Organization will contact the Insured's doctor periodically for a review of the medical information to determine the need for continued inpatient hospital care. Additional days will be certified if they are determined to be necessary. If the Insured incurs additional inpatient charges that are not certified, these charges will not be covered.

ACCIDENTAL DEATH AND DISMEMBERMENT

(Student Only)

When, as a result of an Injury, the Insured sustains a loss as shown below within 365 days of such Injury, the Company will pay the applicable benefit for the loss.

For Loss of:	Benefit Amount
Life.....	\$10,000
One hand or one foot.....	\$ 5,000
Either one hand or one foot and the entire sight of one eye	\$ 5,000
More than one of the above losses due to one Accident.....	\$10,000

Limits and Exclusions

These limitations and exclusions are in addition to the General Exclusions.

Benefits will not be payable for any loss caused by:

1. Bodily or mental infirmity, bacterial infections (except:
a) infections which occur simultaneously with or through a cut or wound sustained as the direct result of an Injury, independent of any other cause; and
b) the accidental ingestion of a contaminated substance), any other kind of disease or hernia;
2. Medical or surgical treatment (except losses that result directly from surgical operations made necessary solely by Injuries which are the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and performed within three months of the Accident);
3. Travel, or flight in or descent from any kind of aircraft unless: a) as a farepaying passenger on a regularly scheduled flight; or b) as a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries;
4. Being under the influence of alcohol or any drug unless administered and taken as prescribed by a doctor;
5. Any Accident or occurrence arising out of or in the course of employment; or
6. Suicide or intentionally self-inflicted Injury while sane or insane.

MEDICAL EVACUATION EXPENSE

When, as a result of an Injury or Sickness, an Insured is hospitalized, the Company will pay for evacuation to the home country or to a facility operated pursuant to the law of the home country for the care and Treatment of injured or ill persons, or to another medical facility in the U.S. Such action must be upon the recommendation of the attending physician and approved by the Claims Administrator of the policy. The Company will pay the actual expense incurred, up to a maximum aggregate benefit of \$10,000. Medical evacuation to the home country will terminate any further coverage under the policy.

REPATRIATION OF REMAINS EXPENSE

In the event of the Insured's death while insured under the policy, the Company will pay the actual expense incurred for preparation and transportation of the remains back to the home country or country of regular domicile. If applicable such action will be in accordance with any international requirements. The Company will pay the actual expenses incurred, up to a maximum aggregate benefit of \$10,000. All expenses must be approved by the Claims Administrator of the policy before the remains are prepared for transportation.

FAMILY COMPANION BENEFIT

In the event that medical evacuation or repatriation is required, up to \$1,000 of the benefit is available for the purchase of a round-trip coach airfare ticket for a family member to accompany an Insured to their home country.

MEDEX PROGRAM

The following description of the MEDEX Program has been included in this brochure for the convenience of the student and in no way affects the coverage provided by the Student Health Insurance Plan described herein.

MEDEX MEMBERSHIP SERVICES

As an International Student participating in this Student Health Insurance Plan, you are automatically enrolled as a Member in the MEDEX Program.

As a participant, MEDEX will provide the assistance services which are reasonably required by a Member residing as an expatriate and/or traveling outside their home country of residence as a direct result of the Member's requiring Emergency Medical Services or suffering death during the period of membership. All evacuations, returns to residence after stabilization and/or repatriation of mortal remains are coordinated by and subject to the prior approval of MEDEX and/or its Regional Medical Advisor. Assistance Services include:

Worldwide 24-Hour Toll-Free Assistance (or collect calls)

MEDEX is available at any time to provide assistance with any medical and travel problem. Call 1-800-527-0218 or 1-410-453-6330.

Emergency Medical Evacuation

In the event a Member is involved in an Accident or suffers a sudden, unforeseen illness requiring Emergency Medical Services and adequate medical facilities are not available, MEDEX will coordinate a medically supervised evacuation to the nearest facility determined by MEDEX to be capable of providing appropriate care.

Repatriation of Mortal Remains

MEDEX will assist in obtaining the necessary clearances for cremation or preparation for the return of a Member's mortal remains.

Emergency Medications, Vaccine, and Blood Transfers

If legally permissible, MEDEX will coordinate the transfer of medications, vaccines or blood upon the prescribing doctor's authorization. The Member will be responsible for the cost of any medication, vaccine or blood and the transportation costs.

Legal Referral Assistance

Should a Member require legal assistance, MEDEX will direct the Member to an attorney as well as render assistance in securing bail bonds or other legal instruments. The Member will be responsible for any contracted legal fees.

Translation Services

MEDEX Multilingual Assistance Coordinators are available to provide immediate translation assistance or can provide referrals to local interpreter services.

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MEDEX (continued from page 7)

Hospital Deposit & Emergency Cash Advance

Upon securing payment from the Member or obtaining the Member's guarantee to reimburse, MEDEX will either wire funds or guarantee required emergency hospital admission deposits, or will assist in arranging cash transfers of the Member's funds. MEDEX will not be responsible for the payment of the cost of Emergency Medical Services.

Transportation to Join Disabled Member

After emergency evacuation coordinated by MEDEX, and if a Member is alone and is hospitalized at the evacuation destination for more than seven (7) days, MEDEX can arrange transportation to the evacuation destination for a single person designated by the Member.

24-Hour Worldwide Medical Referrals

MEDEX provides 24-hour assistance in finding appropriate medical care. Medical referrals are tailored based on the specialty required, the Member's location, language preference, time, etc.

Evaluation and Monitoring of Treatment

MEDEX services include access to Regional Medical Advisors who continually consult with the treating doctors and assess the quality of care and treatment plans for enrolled Members. The evaluation and monitoring begins with the first call to MEDEX and continues through the recovery period.

Assistance with the Coordination of Rehabilitation After an Evacuation

MEDEX helps Members coordinate any ongoing rehabilitation needs following an evacuation.

Emergency Message Transmittals to Family Members

MEDEX can receive and transmit emergency messages between the Member or their family and other involved persons.

Arrangement for the Replacement of Medications and Eyeglasses

MEDEX helps get a Member's lost, stolen, forgotten or depleted prescriptions and eyeglasses replaced quickly.

A toll-free or collect call immediately links you to MEDEX's highly trained, multilingual assistance coordinators, 24 hours a day, every day of the year. Call:

1-800-527-0218 or 1-410-453-6330
Program Number: 995

TREATMENT RECEIVED IN HOME COUNTRY

If the Insured incurs expenses as the result of treatment for a covered Injury or Sickness while in his or her home country or country of regular domicile, the Company will pay covered expenses incurred, except expenses for which the Insured is not required to pay in the absence of this insurance or expenses which would be covered under any other insurance plan.

GENERAL EXCLUSIONS

This plan does not pay benefits for:

1. Treatment, services or supplies which:
 - a) Are not Medically Necessary;
 - b) Are not prescribed by a doctor as necessary to treat an Sickness or Injury;
 - c) Are determined to be experimental/investigational in nature by the Company;
 - d) Are received without charge or legal obligation to pay;
 - e) Would not routinely be paid in the absence of insurance;
 - f) 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. Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion;
4. 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;
5. Congenital conditions and birth abnormalities unless first manifested while covered under the Policy;
6. Plastic or cosmetic surgery unless resulting directly from an Injury which necessitated medical treatment within 24 hours of the Injury. Correction of deviated nasal septum shall be considered as cosmetic surgery for the purposes of the Policy;
7. Any service performed primarily to improve physical appearance without correction or material improvement of a bodily malfunction;
8. Injury caused by, contributed to or resulting from the Insured's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage or for the purpose as prescribed by the Insured's doctor;
9. Expenses for weight increase or reduction and hair growth or removal;
10. Expenses incurred in connection with weak, strained or flat feet, corns, calluses, bunions or toenails;
11. Routine physical examinations, health examinations or preschool physical examinations including routine care of a newborn infant, other than hospital nursery expense of a dependent newborn baby, except as specifically stated;
12. Temporomandibular Joint Dysfunction (TMJ), except for surgical procedures for conditions directly affecting the upper or lower jawbone or associated bone joints;

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SCHEDULE OF BENEFITS

The Company will pay for the expenses listed below, up to the following limits.

MAXIMUM AGGREGATE BENEFIT

\$100,000 maximum lifetime aggregate benefit per Injury or Sickness

COVERED CHARGES are limited to the following Reasonable and Customary (R&C) charges:

Diagnosis and treatment by a legally qualified doctor, surgeon, registered nurse, professional anesthetist, radiologist or physiotherapist	90% of PPO charges if PPO is utilized or 70% of R&C
Hospital room and board, up to semi-private room rate	90% of PPO charges if PPO is utilized or 70% of R&C
Hospital miscellaneous expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia and therapeutic services and supplies	90% of PPO charges if PPO is utilized or 70% of R&C
Emergency care (doctor and facility)	90% of PPO charges if PPO is utilized or 70% of R&C
Laboratory, diagnostic and x-ray examinations	90% of PPO charges if PPO is utilized or 70% of R&C
Prescription drugs and medicines administered as an inpatient	100% of R&C
Payment for outpatient prescription drugs	50% of actual charges
Outpatient Treatment of mental or nervous disorders* Includes alcohol and substance abuse	50% of expenses incurred, to a maximum of 20 visits per policy year
Inpatient Treatment of mental or nervous disorders* Includes alcohol and substance abuse	100% of expenses incurred up to 10 continuous days; 50% thereafter, to a maximum of 35 additional days (100% if certified by the Utilization Review Organization)
Expenses and supplies normally provided for an elective termination of pregnancy	90% of PPO charges if PPO is utilized or 70% of R&C; Up to a maximum of \$750
Rental or purchase charge for durable medical equipment, whichever is less	90% of PPO charges if PPO is utilized or 70% of R&C
Professional ambulance service to the nearest hospital	90% of R&C
Repair of Injury to sound natural teeth	90% of PPO charges if PPO is utilized or 70% of R&C; Up to maximum of \$100 per tooth, \$500 per Injury
Repair of eye glasses, contact lens or hearing aids when required as a direct result of an Injury	90% of PPO charges if PPO is utilized or 70% of R&C
Rehabilitative services medically necessary to restore bodily function lost due to Sickness or Injury. These services are subject to review and approval by the Plan Administrator and Utilization Review Organization.	90% of PPO charges if PPO is utilized or 70% of R&C
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	90% of PPO charges if PPO is utilized or 70% of R&C; up to maximum of \$1,000 per year
Specific Disease Waiver: The following Pre-Existing Conditions and diseases, and only these conditions and diseases, will be considered a Sickness under the plan even though manifested before coverage began.	90% of PPO charges if PPO is utilized or 70% of R&C; Up to a maximum of \$1,000 per year Includes: malaria, dysentery, tuberculosis, cholera, shigellosis, typhoid fever, typhus, diphtheria, yellow fever, schistosomiasis, and mosquito borne viral encephalitis.

The State of South Carolina mandates coverage for the following benefits: care and treatment of congenital cleft lip or palate or both; hospital confinement of 48 hours following mastectomy and prosthetic devices and breast reconstruction; diabetes equipment, supplies, medication and outpatient self-management training; mammograms; pap smears; and prostate cancer examinations. Please see the Policy on file with the University for full details.

GENERAL EXCLUSIONS (continued from page 9)

13. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, except for repair of Injury to sound natural teeth;
14. Eye examinations, contact lenses, eyeglasses, replacement of eyeglasses or prescription thereof or radial keratotomy or laser surgery; hearing aids or prescriptions or examinations, except as required for repair caused by Injury;
15. Expenses that would be payable, or medical treatment that is available, under any governmental or national health plan for which the Insured could be eligible;
16. Expense incurred in connection with birth control, sterilization or sterilization reversal, including surgical procedures and devices;
17. Expenses resulting from a motor vehicle accident if the Insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are insured under the Policy;
18. Expenses for maintenance therapy which is defined as those therapy services rendered to an Insured who is no longer making documentable progress to maintain the level of progress previously attained;
19. Expenses incurred as a result of diagnostic or surgical procedures in connection with infertility unless caused by an Injury or Sickness;
20. Expenses for physiotherapy unless recommended by the University's Student Health Center or other Doctor;
21. Claims arising out of participation by an Insured in interscholastic, intercollegiate or professional sports events, racing or speed contests, skin diving or sky diving, or mountaineering (where ropes or guides are customarily used); or
22. Suicide or attempted suicide while sane or insane or intentionally self-inflicted Injury.

PRE-EXISTING CONDITION LIMITATION

Expenses incurred for Pre-Existing Conditions will not be covered. This limitation will not apply if, during the period immediately preceding the Insured's effective date of coverage under this Policy, the Insured was covered under prior creditable coverage for six (6) consecutive months. This waiver will apply only if the Insured becomes eligible and applies for coverage within 63 days of termination of his or her prior coverage. Prior creditable coverage of less than six (6) months will be credited toward satisfying the Pre-Existing Condition limitation. The Insured must provide the Company with proof of prior creditable coverage.

EXCESS COVERAGE

This plan of insurance is secondary and provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any other valid and collectible insurance. If the Insured is covered by other valid and collectible insurance, all benefits payable by such insurance will be determined before benefits will be paid by this plan. This plan is the second payor to any other insurance having primary status or no coordination or non-duplication of benefits provision. Benefits paid by this plan will not exceed: 1) any applicable plan maximums; and 2) 100% of the compensable expenses incurred when combined with benefits paid by any other valid and collectible insurance.

DEFINITIONS

The following important definitions apply to this plan:

Accident means a sudden, unforeseeable external event which results in an Injury. The Accident must occur while the Insured is covered under the Policy.

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

1. The patient's life or health would be in serious jeopardy;
2. Bodily functions would be seriously impaired; or
3. A body organ or part would be seriously damaged.

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 above listed complications.

Injury means bodily injury due to an Accident which: 1) results solely, directly and independently of disease, bodily infirmity or any other causes; 2) occurs after the Insured's effective date of coverage; and 3) 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 a single injury.

Insured means an eligible student or dependent for whom application has been accepted, and proper premium payment has been made and who is therefore insured under the policy.

Pre-Existing Condition means a Sickness or Injury or pregnancy existing on the Insured's effective date of coverage under the Policy for which medical care, treatment, diagnosis or advice was received or recommended within the six (6) months prior to the Insured's effective date of coverage under the Policy. Pregnancy, including complications of pregnancy, will not be considered a pre-existing condition.

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DEFINITIONS (continued from page 14)

Reasonable and Customary (R&C) means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of: 1) the actual amount charged by the provider; 2) the negotiated rate, if any; or 3) the charge which would have been made by the provider of medical services for a comparable service or supply made by other providers in the same geographic area, as reasonably determined by the Company, for the same service or supply.

Sickness means illness or disease which begins after the effective date of an Insured's coverage, which are not a Pre-Existing Condition. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

CERTIFICATION OF QUALIFYING HEALTH PLAN COVERAGE

If a Covered Person is no longer eligible to be insured under the plan, the Covered Person should request a Certification of Qualifying Health Plan Coverage from Renaissance Agencies, Inc. 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.

AUTHORIZED REPRESENTATION

In accordance with state and federal rules and regulations, we will not disclose individual information without authorization. This includes disclosures to family members for insured individuals who have reached the age of majority.

If the Covered Person would like to authorize an additional party to act as a personal representative for matters pertaining to this insurance plan, we must have an Authorization Form on file. To request a form, please contact Renaissance Agencies, Inc. at the address below or complete a form via the internet at: www.renstudent.com.

SUMMARY OF PRIVACY POLICY

We strongly believe in maintaining the confidentiality of the personal information we obtain and/or receive about Covered Persons and we are committed to protecting the privacy of Covered Persons. We do not disclose any nonpublic information about Covered Persons to anyone, except as permitted or required by law. We do not sell or otherwise disclose Covered Person's personal information to anyone for purposes unrelated to our products and services. We maintain physical, electronic and procedural safeguards that comply with federal and state regulations to protect information about Covered Persons from unauthorized disclosure. We may disclose any information we believe necessary to conduct our business as is legally required. Covered Persons have the right to access, review and correct all personal information collected. Covered Persons may review this Privacy Policy in its entirety, or the Privacy Policies of other entities servicing the Policy, by writing to the address or visiting the website shown below. Covered Persons may also submit a request, in writing, to review your information at the address below.

Renaissance Agencies, Inc.
Attention Privacy Manager
P.O. Box 2300
Santa Monica, CA 90407-2300
Phone: (800) 537-1777
Facsimile: (310) 394-0142
Website: www.renstudent.com

NATIONWIDE LIFE HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Nationwide; for purposes of this policy, "Nationwide" or "We" means the health plan components of Nationwide Life Insurance Company ("Nationwide Life"), which is a hybrid covered entity and for which Nationwide Health Plans ("NHP"), which is a business associate of Nationwide Life Insurance Company, performs certain administrative services relating to the Nationwide Life health insurance products. As permitted by law, Nationwide will share protected health information of members as necessary to carry out treatment, payment, and health care operations.

We are required by HIPAA and certain state laws to maintain the privacy of our members' protected health information and to provide members with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of the revised notices will be available online or may be obtained by mailing a request to your designated contact point under the Summary of Privacy Policy on page 16.

Protected health information that is the subject of this Notice is information that is created or received by Nationwide; and relates to the past, present or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member for which there is a reasonable basis to believe the information can be used to identify the member. Protected health information includes information of persons living or deceased.

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HIPAA NOTICE (continued from page 17)

The following components of a member's information also are considered protected health information:

1. names;
2. street address, city, county, precinct, zip code;
3. dates directly related to a member, including birth date, admission date, discharge date, and date of death;
4. telephone numbers, fax numbers, and electronic mail addresses;
5. Social Security numbers;
6. medical record numbers;
7. health plan beneficiary numbers;
8. account numbers;
9. certificate/license numbers;
10. vehicle identifiers and serial numbers, including license plate numbers;
11. device identifiers and serial numbers;
12. Web Universal Resource Locators (URL'S);
13. biometric identifiers, including finger and voice prints;
14. full face photographic images and any comparable images; and
15. any other unique identifying number, characteristic, or code.

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HIPAA NOTICE (continued from page 18)

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your authorization. Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing, unless we have taken any action in reliance on the authorization.

Disclosures for Treatment. We will make disclosures of your protected health information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request certain of your protected health information that we hold in order to make decisions about your care.

Uses and Disclosures for Payment. We will make uses and disclosures of your protected health information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health benefits plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your protected health information as necessary, and as permitted by law, for our health care operations, which include credentialing health care providers, peer review, business management, accreditation and licensing, utilization review and management, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, and other functions related to your health benefits plan. We may also disclose your protected health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Family and Friends Involved in Your Care. With your approval, we may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. If you have designated a person to receive information regarding payment of the premium on your long-term care or Medicare supplemental policy, we will inform that person when your premium has not been paid. We may also disclose limited protected health information

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HIPAA NOTICE (continued from page 19)

to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, etc. At times it may be necessary for us to provide some of your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information by contract.

Communications With You. We may communicate with you regarding your claims, premiums, or other things connected with your health plan or insurance. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You must request such confidential communication in writing.

Other Health-Related Products or Services. We may, from time to time, use your protected health information to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products or services which may be available to you as a member of the health plan. For example, we may use your protected health information to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you manage your illness better is available to you as a health plan member. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Information Received Pre-Enrollment. We may request and receive from you and your health care providers protected health information either prior to your enrollment in the health plan or the issuance of your policy. We will use this information to determine whether you are eligible to enroll either in the health plan or for a policy, and to determine your rates. We will protect the confidentiality of that information in the same manner as all other protected health information we maintain and, if you either do not enroll in the health plan or if the policy is not issued, we will not use or disclose the information about you we obtained for any other purpose without your authorization.

**INTERNATIONAL STUDENT INSURANCE PLAN
QUICK REFERENCE GUIDE**

*this page contains useful information
detach and carry with you at all times along with your ID Card*

Insurance Company: Nationwide Life Insurance Company
Policy Number: 302-068-3905

Frequently Asked Questions (FAQs)

Am I covered? When does my coverage end?

For questions regarding when your coverage begins and ends, if you and/or your dependents are eligible for coverage and how to enroll, contact Renaissance Agencies, Inc. at **1-800-537-1777**. The company does not send renewal notices to students when their coverage terminates. It is the student's responsibility to renew their insurance within 30 days after their coverage ends to avoid a lapse in coverage. You cannot renew coverage over the phone.

If you need a receipt for payment or proof of coverage, contact Renaissance Agencies, Inc. at **1-800-537-1777**.

Where do I get an ID card?

Detach and retain the ID card below and use this card to obtain Treatment after you have enrolled in the plan. If you need additional cards, you may obtain an ID card from the school or by accessing the website **www.renstudent.com**.

Your ID card may also be used for your covered dependents.

Who do I contact about changing my name or mailing address?

Contact Renaissance Agencies, Inc. at **1-800-537-1777**.

How do I get a refund of my payment if I no longer want the insurance coverage?

There are no premium refunds, unless the Insured returns to the home country or country of regular domicile. **Contact your school** if you qualify for a refund. A pro-rata refund will be issued only upon written proof from the University that the Insured is no longer eligible for coverage. Please allow 4 to 6 weeks for refund of premium.

What is covered under the plan?

Please refer to the health insurance brochure for a list of benefits or contact Personal Insurance Administrators, Inc. at **1-800-468-4343**.

Underwritten by:

NATIONWIDE LIFE INSURANCE COMPANY

Insured _____

Student of

CHARLESTON SOUTHERN UNIVERSITY
2007-2008 INTERNATIONAL STUDENT INSURANCE PLAN
Policy No. 302-068-3905

*Both the effective and termination dates of coverage are at
12:01 a.m. and are subject to verification by the Company.*



MEDEX Program No. 995
1-800-527-0218

What do I do if I get sick or injured?

In the event of Injury or Sickness:

1. The insured person should obtain Treatment from the nearest doctor or hospital. You may use any doctor or hospital you choose, but using the doctors and hospitals available through the Community Care Network (PPO) may decrease your costs. For a complete listing of the PPO hospital and Doctor facilities, call **1-800-226-5116** or access the internet website: **www.myfirsthealth.com**.
2. If you go to a physician's office or to the hospital, be sure to show your insurance ID card. Dependents covered under the plan do not receive separate ID cards and may use the insured student's ID card to obtain Treatment. If the physician or hospital needs to verify coverage for you or your dependents, have them call Personal Insurance Administrators, Inc. at **1-800-468-4343**.
To obtain pre-certification prior to hospitalization, call First Health Network (FHN) at 1-800-572-5508.

How do I get my medical bills paid?

1. After you receive Treatment, complete the insurance company claim form.
 - a) Claim forms are available from Personal Insurance Administrators, Inc. or you may download a claim form from **www.renstudent.com**.
 - b) Be sure to include your policy number (as shown on your ID card) on the claim form.
 - c) Answer all the questions and be sure to sign the claim form before submitting it.
2. If you have any other expenses such as medicines, x-rays or laboratory charges, be sure to attach these bills to the claim form.
3. Send your claim form and all other bills to Personal Insurance Administrators, Inc. at the address below. Try to have all itemized bills attached to the same claim form.
 - a) Please do not send bills without completed claim form. Bills cannot be considered unless all the information required on the claim form is submitted.
 - b) A properly completed claim form must be submitted for each Injury or Sickness.
4. All claim form and bills should be sent to:
Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
5. If you have questions about the status of your claim after it has been submitted, please call Personal Insurance Administrators, Inc. at **1-800-468-4343**.

A claim must be submitted within 90 days after an Injury or Sickness has occurred in order for the claim to be paid.

Always carry your identification card with you.

For questions regarding claims and coverage, contact:

**PERSONAL INSURANCE
ADMINISTRATORS, INC.**
P.O. Box 6040
Agoura Hills, CA 91376-6040
Toll Free: 1-800-468-4343
www.piaclaims.com

NOTE: Benefits are subject to payment of appropriate premium and verification of eligibility.



For information on PPO Providers,
access **www.myfirsthealth.com**
or call **1-800-226-5116**