STUDENT BLANKET ACCIDENT AND SICKNESS POLICY

This Policy is a legal contract between the Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder against loss covered by this Policy subject to its provisions, limitations and exclusions. This Policy provides accident and sickness insurance to Covered Persons. The persons eligible to be Covered Persons are all persons described in the Description of Class section of the Schedule of Benefits.

This Policy is issued in consideration of payment of the required premium when due and the statements set forth in the signed Application For Student Blanket Accident and Sickness Insurance Policy which is attached to and made part of this Policy.

This Policy begins on the Policy Effective Date shown in the Schedule of Benefits and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid.

This Policy is governed by the laws of the state in which it is delivered.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Policy:

[Signatures]

President

Secretary

NON-RENEWABLE ONE-YEAR TERM INSURANCE

PLEASE READ THIS POLICY CAREFULLY

Non-Participating Policy
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
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</thead>
<tbody>
<tr>
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<td>Schedule of Benefits</td>
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<td>2</td>
<td>Definitions</td>
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SECTION 1 - SCHEDULE OF BENEFITS

Policyholder Effective Date: August XX, 2006
Policyholder Termination Date: August XX, 2007

CLASS

1  Graduate students receiving a full tuition waiver as part of their graduate assistantship award; undergraduate and ESL international students holding F or J visas; undergraduate and graduate students enrolled in programs that require proof of health insurance; and graduate student receiving fellowships that fully fund their tuition.

2  Eligible Dependents of Class 1.

Subject to the terms of this Policy, Benefits will be provided only for the coverages indicated below; and only up to the amounts shown.

COVERAGE

COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. The PPO for this Policy will be selected by the Company. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to policy provisions. A Covered Person has the option to use a PPO provider or a non-PPO provider. Benefits applicable to both types of providers are shown below.

For treatment or care received outside the PPO geographic service area, benefits for Eligible Expense will be payable at the non-PPO level. However, if such treatment is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

Benefits payable under the Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its providers except as otherwise noted for services received at the Student Health Center.

Benefits payable under the Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the providers except as otherwise noted for services received at the Student Health Center.

Maximum Benefit Limit per Injury or Sickness Per Policy Year $500,000
Lifetime Maximum Benefit (All Accidents and Sicknesses Combined) $1,000,000

<table>
<thead>
<tr>
<th>*Deductible Amount per Policy Year</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Covered Person</td>
<td>$250</td>
<td>$300</td>
</tr>
<tr>
<td>Per Family</td>
<td>$750</td>
<td>$900</td>
</tr>
</tbody>
</table>

* PPO and Non-PPO Deductibles apply separately

<table>
<thead>
<tr>
<th>*Out-of-Pocket Limit:</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Covered Person</td>
<td>$2,500</td>
<td>$4000</td>
</tr>
<tr>
<td>Per Family</td>
<td>$7,500</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

*PPO and Non-PPO Out-of-Pockets Maximums apply separately.
SECTION 1 - SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>BENEFIT AMOUNT</th>
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</thead>
<tbody>
<tr>
<td>COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE</td>
<td>PPO  Non-PPO</td>
</tr>
</tbody>
</table>

Covered Percentage

The Covered Percentage shown above, unless otherwise indicated in the Schedule of Benefits, will apply to the Eligible Expenses shown below during the Policy Year until the Out-of-Pocket Limit is reached. Thereafter, the Covered Percentage will be raised to 100% for the remainder of that Policy Year.

Referral Service

A referral from the Student Health Service is required before benefits are payable. (Does not apply if: (a) the Student Health Service is closed; (b) medical care is received when Student is more than 30 miles from campus; (c) medical care is obtained by a Student who is not eligible to use the Student Health Service; (d) for maternity; (e) for mental or nervous disorders or (f) for Emergency Medical Condition, however, the Student must return to the Student Health Service for a referral or follow up care.) Benefits for Eligible Expenses incurred for medical care or treatment rendered for which no referral is obtained will be excluded from coverage.

The Deductible Amount will be waived when services are provided at the Student Health Service. The applicable Deductibles shall apply to all of the exceptions to the referral requirement shown above.

ELIGIBLE COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSES:

HOSPITAL EXPENSE (The Covered Person should notify the Company of all Hospital Confinements)
Daily Room and Board Maximum:

• Miscellaneous Hospital Expense.
• Pre-Admission Testing.
• Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is:
  rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service.
• Physiotherapy during Hospital Confinement (In no event will the Maximum Number of Visits exceed a combined total of 10 per Policy Year for PPO and Non-PPO).

SURGICAL EXPENSE (Inpatient or Outpatient, including Anesthesia)
Assistant Surgeon (Inpatient only)

IN-HOSPITAL DOCTOR’S FEES
Maximum Number of Visits per Day 1

OUTPATIENT EXPENSE
Day Surgery Facility/Miscellaneous (The Covered Person should notify the Company of a Scheduled Day Surgery)
When scheduled surgery is performed in a Hospital or outpatient facility, including the use of the operating room, laboratory tests and x-ray examinations (including professional fees), anesthesia, infusion therapy, drugs or medicines and supplies, therapeutic services (excluding Physiotherapy or take home drugs and medicines). Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index.
### SECTION 1 - SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Accident and Sickness Expense</td>
<td>PPO</td>
</tr>
<tr>
<td>Benefit</td>
<td></td>
</tr>
<tr>
<td>Amount</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Accident and Sickness Expense</td>
<td></td>
</tr>
<tr>
<td>Coverage</td>
<td></td>
</tr>
<tr>
<td>PPO</td>
<td></td>
</tr>
<tr>
<td>Non-PPO</td>
<td></td>
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</tbody>
</table>

#### ELIGIBLE COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSES:

**OUTPATIENT EXPENSE (Continued)**

- **Hospital Emergency Room and Non-Scheduled Surgery**
  For use of Hospital Emergency Room, including attending Doctor’s charges, operating room, laboratory and x-ray examinations, supplies.

<table>
<thead>
<tr>
<th>Covered Percentage</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

- **A** Copayment of $150 will apply to each visit to the Hospital Emergency Room. This Copayment will be reduced to $50 if the Covered Person is admitted to the Hospital as an inpatient.

- **B** Copayment is a fixed dollar amount which is paid by the Covered Person for certain Eligible Expenses incurred before benefits become payable.

- **For Laboratory and X-ray Examinations**
  *When the services above are rendered at the Student Health Service, the benefit will be payable at 80% of the amount listed in the Student Health Service fee schedule.*

- **For Tests and Procedures**
  For diagnostic services and medical procedures performed by the Doctor, other than Doctor’s visits, physiotherapy, x-rays and laboratory procedures.

  *When the services above are rendered at the Student Health Service, the benefit will be payable at 80% of the amount listed in the Student Health Service fee schedule.*

**CAT Scan/MRI**

**Radiation Therapy and Chemotherapy**

**Durable Medical Equipment and Orthopedic Appliance**

(for rental or purchase when prescribed by the attending Doctor.)

- **Prosthetic Devices:**
  Maximum Amount per lifetime of the Covered Person $10,000

- **Other than Prosthetic Devices:**
  Maximum Amount per lifetime of the Covered Person $5,000

**Physiotherapy:**

- Maximum Number of Visits per Day 1
- Maximum Number of Visits per Policy Year 30
SECTION 1 - SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>BENEFIT AMOUNT</th>
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</thead>
<tbody>
<tr>
<td>COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT</td>
<td>PPO</td>
</tr>
<tr>
<td></td>
<td>Non-PPO</td>
</tr>
</tbody>
</table>

**ELIGIBLE COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSES:**

<table>
<thead>
<tr>
<th><strong>OUT OF HOSPITAL DOCTOR’S FEES EXPENSE</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Number of Visits per Day</td>
<td>1</td>
</tr>
</tbody>
</table>

*Benefits do not apply when related to surgery or physiotherapy.*

*Includes injections when administered in the Doctor’s office.*

**CONSULTANT’S FEES EXPENSE**

**AMBULANCE EXPENSE** (for Emergency Medical Condition only)

<table>
<thead>
<tr>
<th>Covered Percentage</th>
<th>70%</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Amount per trip:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land Ambulance</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>$1,000</td>
<td></td>
</tr>
</tbody>
</table>

**DENTAL EXPENSE** (for Injury and removal of full bony impacted wisdom teeth only)

**PRESCRIBED MEDICINES EXPENSE**

<table>
<thead>
<tr>
<th>Maximum Amount per Policy Year</th>
<th>$2,000</th>
</tr>
</thead>
</table>

**Copayment per Prescription – limited to a 30 day supply:**

<table>
<thead>
<tr>
<th>Generic</th>
<th>$15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name</td>
<td>$30</td>
</tr>
</tbody>
</table>

The Copayment is waived for prescriptions filled at the Student Health Service.

**Copayment is a fixed dollar amount which is paid by the Covered Person for certain Eligible Expenses incurred before benefits become payable.**

**MENTAL AND NERVOUS DISORDERS EXPENSE**

For Inpatient:

<table>
<thead>
<tr>
<th>Maximum Number of Days per Policy Year</th>
<th>30*</th>
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</thead>
</table>

*In no event will the Maximum Number of Days per Policy Year for Inpatient Mental and Nervous Disorder Expense exceed 30 when combined with the Maximum Number of Days per Policy Year for Inpatient Alcoholism and Substance Abuse Expense.*

For Outpatient:

<table>
<thead>
<tr>
<th>Maximum Number of Visits per Policy Year</th>
<th>30*</th>
</tr>
</thead>
</table>

*In no event will the Maximum Number of Visits per Policy Year for Outpatient Mental and Nervous Disorder Expense exceed 30 when combined with the Maximum Number of Visits per Policy Year for Outpatient Alcoholism and Substance Abuse Expense. Additional outpatient visits may be provided in lieu of inpatient visits.*
ELIGIBLE COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSES:
ALCOHOLISM AND SUBSTANCE ABUSE EXPENSE

For Inpatient:
Maximum Number of Days per Policy Year 30*

*In no event will the Maximum Number of Days per Policy Year for Inpatient Alcoholism and Substance Abuse Expense exceed 30 when combined with the Maximum Number of Days per Policy Year for Inpatient Mental and Nervous Disorder Expense.

Outpatient:
Maximum Number of Visits per Policy Year 30*

*In no event will the Maximum Number of Visits per Policy Year for Outpatient Alcoholism and Abuse Expense exceed 30 when combined with the Maximum Number of Visits per Policy Year for Outpatient Mental and Nervous Disorder Expense. Additional outpatient visits may be provided in lieu of inpatient visits.

See Coverage Provision for the following mandated benefits:

DIABETES EXPENSE
PRESCRIBED CONTRACEPTIVE EXPENSE
MAMMOGRAPHY AND CERVICAL CYTOLOGICAL SCREENING EXPENSE
BREAST CANCER TREATMENT EXPENSE
RECONSTRUCTIVE BREAST SURGERY EXPENSE
PROSTATE CANCER SCREENING EXPENSE
TMJ EXPENSE
BONE MASS MEASUREMENT EXPENSE
CHLAMYDIA SCREENING TEST EXPENSE
DRUG TREATMENT OF CHILDREN’S CANCER EXPENSE
DENTAL ANESTHESIA EXPENSE
AUTISM TREATMENT EXPENSE
## SECTION 1 - SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>BENEFIT AMOUNT</th>
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</thead>
<tbody>
<tr>
<td><strong>COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT</strong></td>
<td></td>
</tr>
<tr>
<td><strong>REPATRIATION OF REMAINS EXPENSE BENEFIT</strong></td>
<td></td>
</tr>
<tr>
<td>Maximum Amount per Injury or Sickness</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>MEDICAL EVACUATION EXPENSE BENEFIT</strong></td>
<td></td>
</tr>
<tr>
<td>Maximum Amount per Injury or Sickness</td>
<td>$25,000</td>
</tr>
</tbody>
</table>
SECTION 2 - DEFINITIONS

Whenever used in this Policy:

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

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

"Complications of Pregnancy" means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis; or
- pre-eclampsia; or
- eclampsia; puerperal infection; or
- RH Factor problems; or
- severe loss of blood requiring transfusion; or
- intrauterine fetal growth retardation; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum; and (d) similar conditions not medically distinct from a difficult pregnancy.

Complications of Pregnancy also include:
- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion.)

"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.

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

"Dependent" means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's unmarried child under age 19 if he is:
(a) dependent upon the Covered Student for support; and
(b) living in the household of the Covered Student; or

An unmarried child age 19 but less than 25 is a dependent if he is:
(a) dependent upon the Covered Student for support; and
(b) a full-time student for five months or more at an accredited institution of higher learning in each calendar year since reaching age 19.

The term "child" includes a Covered Student's:
(a) legally adopted child;
(b) child who has been placed in the Covered Student's home pending adoption procedures; and
(c) step-child if such child resides with the Covered Student and depends on the Covered Student for full support.
"Doctor" as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s Immediate Family Member.

"Durable Medical Equipment" consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

"Elective Treatment" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage.

Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; botox injections; treatment of infertility and routine physical examinations.

"Eligible Expense" as used herein 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 the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention or within 72 hours after onset of symptoms a reasonable person could believe this condition would result in: (a) death; (b) placement of the Covered Person's health in jeopardy; (c) serious impairment of bodily functions; (d) serious dysfunction of any body organ or part; or (e) in the case of a covered pregnant woman, 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;
SECTION 2-DEFINITIONS (continued)

(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment 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 or 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 in which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care. The term "Hospital" includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; (c) a mental health hospital if supervised and licensed by the Department of Mental Health; and (d) 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.

“Hospital Confinement/Hospital Confined” means a stay of at least 18 consecutive hours or for which a room and board charge is made.

“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 solely, directly and independently of disease, bodily infirmity or any other causes; (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.
SECTION 2-DEFINITIONS (continued)

"Intensive Care Unit" means a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.

“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.

“Mental or Nervous Disorder(s)” means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

"One Sickness" means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

Orthopedic Brace and Appliance” means a supportive device or appliance used to treat a Sickness or Injury.

"Personal Item" is one which is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

“Physiotherapy” means any form of the following administered by a Doctor for treatment of Sickness or Injury: physical or mechanical; diathermy; ultra-sonic therapy; heat treatment in any form; or manipulation or massage.

"Policy Year" means the period of time measured from the Effective Date to the Termination Date shown on the Schedule of Benefits.

"Pre-Existing Condition" means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services within the 12 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.
SECTION 2-DEFINITIONS (continued)

"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.

“Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date shown in the Schedule of Benefits.

"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.

"Sound Natural Teeth" means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

“Spouse” means the Covered Student’s legal Spouse.

"Student Health Services" means any organization, facility or clinic operated, maintained or supported by the Policyholder.
SECTION 3 – EFFECTIVE DATE OF COVERAGE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the signed Application at 12:01 a.m. Standard Time at the address of the Policyholder where this Policy is delivered.

Eligible Persons

Student:
Each student, as determined by the school in which he or she is enrolled, is eligible and must enroll for coverage under this Policy unless a waiver form showing comparable coverage is received by the Policyholder.

An eligible student must attend classes at the Policyholder’s school for at least 31 days of the period for which he or she is enrolled.

The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company’s only obligation is to refund premium.

Dependent:
A Dependent may become eligible for coverage under the Policy only when the student becomes eligible.

Covered Person’s Effective Date

Covered Student:
The coverage of an eligible Student who enrolls for coverage under this Policy shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the date for which the first premium for the Covered Student’s coverage is paid; or (3) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

The coverage of a student who enrolls for coverage under this Policy after the Policy Effective Date shall take effect on the later of the following dates: (1) the date for which the first premium for the Covered Student’s coverage is paid; or (2) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

However, if enrollment for coverage under this Policy is made more than 31 days following the date the Eligible student becomes eligible, then his or her insurance will become effective only if and when the Company gives its written consent.

Covered Dependent:
A covered Dependent’s coverage shall take effect on the latest of the following dates: (1) the date the coverage for the Covered Student becomes effective; (2) the day after the date the Dependent is enrolled for coverage, provided premium is paid when due; or (3) the date the dependent qualifies as a Dependent, provided premium is paid when due.

If enrollment for coverage is made more than 31 days following the date the Dependent becomes eligible, then his or her insurance will become effective only if and when the Company gives its written consent.

A newborn child and adopted child shall be insured for Injury or Sickness, including the necessary care and treatment of premature birth and medically diagnosed congenital defects and birth abnormalities as well as nursery care for newborn well-baby furnished any infant from the moment of birth for the number of days benefits are payable for the mother’s maternity care for an initial period of thirty-one days. To continue the insurance beyond this initial 31 day period, the Covered Student must notify the Company of the birth in writing or adoption in writing and pay any additional premium required for the child's insurance within the 31 day period.
SECTION 3 – EFFECTIVE DATE OF COVERAGE (continued)

The Policyholder or its authorized representative agrees to submit to the Company within 90 days after the effective date of each Covered Person's insurance: (1) the name of each person who enrolled for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such Covered Person. The insurance of those Covered Persons whose names and premiums were received more than 90 days after the date the insurance would have become effective will take effect on the date such name and premium is received by the Company or its authorized representative except as provided in the previous paragraph.

Continuously insured means a person has been continuously insured under this Policy and prior Student Health Insurance policies issued to the school. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for Expenses payable under prior policies in the absence of this Policy. Previously insured Dependents and students must re-enroll for coverage in order to avoid a break in coverage within 31 days of the end of the prior coverage to maintain coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs, the definition of Pre-Existing Condition will apply in determining coverage of any condition which existed during such break.
SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS

TERMINATION OF POLICY
This Policy may, at any time, be terminated by mutual written consent of the Company and the Policyholder. This Policy terminates automatically on the earlier of: (1) the Policy Termination Date shown in the Schedule of Benefits; or (2) the premium due date if premiums are not paid when due. Termination takes effect at 11:59 p.m. Standard Time at the Policyholder's address on the date of termination.

The Policy is issued for the Policy Term stated in the Schedule of Benefits on the Effective Date of the Policy. If the Policyholder desires to continue coverage, a new Policy will be issued for a new Policy Term, subject to the then current underwriting requirements.

TERMINATION OF STUDENT COVERAGE
Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:
(a) the date this Policy terminates;
(b) the last day for which any required premium has been paid;
(c) the date on which the Covered Student withdraws from the school because of entering the armed forces of any country (Premiums will be refunded on a pro-rata basis when written request is made).

If withdrawal from school is for other than the Covered Student's entry into the armed services, no premium refund will be made. A Student will be covered for the policy term for which they are enrolled and for which premium has been paid unless he or she withdraws from school within the first 31 days.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

Note: Each Student must re-enroll each year even in the event the Policy is renewed.

TERMINATION OF DEPENDENT COVERAGE
Insurance for a Covered Student's Dependent will end when insurance for the Covered Student ends.

Insurance for Dependents will also terminate on the first premium due date after any of the following events occur:
(a) the end of the month in which status as a Dependent ends;
(b) Dependent insurance is deleted from this Policy (any unearned premium will be refunded); or
(c) at the end of the last period for which any required premium has been paid.

Insurance may be continued for incapacitated dependent children who reach the age at which insurance would otherwise cease. The dependent child must be:

(a) chiefly dependent upon the Covered Student for support; and
(b) incapable of self-sustaining employment because of mental or physical handicap.

Proof of the incapacity and dependency must be furnished to the Company by the Covered Student within 31 days after insurance would terminate because of age and as often as the Company may subsequently request but not more often than once a year after the 2 year period following the child's attainment of the limiting age.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.
SECTION 4 -TERMINATION OF COVERAGE, EXTENSION OF BENEFITS (continued)

EXTENSION OF BENEFITS. If the Covered Person is confined to a Hospital 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 Eligible Expenses incurred until the earliest of: (1) the end of Sickness or Injury; (2) the end of the 90 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

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

CERTIFICATES OF CREDITABLE COVERAGE. The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under this Policy is terminated. In addition, Certificates shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time.
SECTION 5 - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. This Policy, the Application and any attached papers make up the entire contract between the Policyholder and the Company. All statements made by the Policyholder or any Covered Person will, in the absence of fraud, be deemed representations and not warranties. No written statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person or his or her beneficiary or personal representative.

No change in this Policy shall be valid unless approved by an officer of the Company. The approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

INCONTESTABILITY. The validity of this Policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

PREMIUMS. The Company sets the premiums that apply to the coverage provided under this Policy. Those premiums are shown in a notice given to the Policyholder with or prior to delivery of this Policy. The Company has the right to adjust the premium rate when the terms of this Policy are changed. The Policyholder will be given notice of such premium adjustment at least 30 days before the date it is to take effect unless the change in Policy terms is to take effect before the 30 days.

All premium must be paid to the Company prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received by the Company or its authorized representative.

RENEWAL OF POLICY. This Policy is issued for the Policy Term shown in the Schedule of Benefits. If the Policyholder wishes to continue coverage, the Company will issue a new Policy for a new Policy Term, subject to the then current underwriting requirements.

NOTICE OF CLAIM. Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to the Company at Pearce Administration, P.O. Box 2439, Florence, SC 29503, with information sufficient to identify the Covered Person, shall be deemed notice to the Company.

CLAIM FORMS. Upon receipt of a written notice of claim, the Company will give the claimant such forms as are usually given by the Company for filing proofs of loss. If such forms are not given within 10 working days after the receipt of such notice, the claimant can fulfill the terms of this Policy as to proof of loss by giving written proof of: (a) the occurrence of the loss; and (b) the nature of the loss; and (c) the extent of the loss.

PROOFS OF LOSS. Written proof of loss must be given to the Company within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS. Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by the Company.
SECTION 5 - GENERAL PROVISIONS (continued)

PAYMENT OF CLAIMS. Benefits payable for covered health care Eligible Expenses incurred by a Covered Person are payable directly to the provider. If any such Eligible Expenses have been paid by the Covered Person, the benefit for those Eligible Expenses will be paid to the Covered Student. All other benefits provided by this Policy will be payable to the Covered Student. If the Covered Student dies, the Company will pay any accrued benefits at the time of death to the beneficiary or, if no beneficiary is designated and surviving the Covered Student, then as follows: (a) the Covered Student's Spouse; (b) children; (c) parents; (d) brothers or sisters; or (e) legal guardian, if a minor; (f) otherwise to the Covered Student's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee’s property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at the Company’s option, to any relative by blood or connection by marriage of the payee, who, in the Company’s opinion, has assumed the custody and support of the minor or responsibility for the incompetent person’s affairs.

Any payment the Company makes in good faith fully discharges the Company’s liability to the extent of the payment made.

ASSIGNMENT. This Policy is non-assignable. The Covered Student may not assign any of his or her rights, privileges or benefits under this Policy.

PHYSICAL EXAMINATION AND AUTOPSY. The Company at its own expense has the right to have a Doctor examine a Covered Person when and so often as it deems reasonably necessary while there is a claim pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS. No one may sue the Company for payment of claim: (a) less than 60 days after due proof of claim is furnished; or (b) more than three years after the date proof of claim is required by this Policy.

RECORDS MAINTAINED. The Policyholder or its authorized representative shall maintain records of each person covered. The records shall show all data that is needed to administer this Policy.

EXAMINATION AND AUDIT. The Company shall be allowed to examine and audit the Policyholder's books and records which pertain to this Policy at reasonable times. The Company must also be allowed to do this within 3 years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

CONFORMITY WITH STATE STATUTES. Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

POLICY ERROR. Clerical errors, whether by the Policyholder or the Company, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect nor extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

NOT IN LIEU OF WORKERS’ COMPENSATION. This Policy is not a Workers’ Compensation policy. It does not provide Workers’ Compensation benefits.
SECTION 5 - GENERAL PROVISIONS (continued)

RIGHT OF RECOVERY. As a condition to receiving benefits under this policy, the Covered Person (or, if he or she is deceased, an authorized representative of the Covered Person) agrees, except as may be limited or prohibited by applicable law:

(a) to reimburse the Company for any such benefits paid to or on behalf of the Covered Person, if such benefits are recovered, in any form, from any Third Party or Coverage; and
(b) if the Covered Person is a minor or is not competent to make this agreement, the legal guardian of the Covered Person’s property makes the agreement on the Covered Person’s behalf as a condition to receiving benefits under this Policy on behalf of the Covered Person. If the Covered Person has no guardian for his or her property, the person or persons who, in the Company’s opinion, have assumed the custody and support of the minor or responsibility for the incompetent person’s affairs make the agreement on the Covered Person’s behalf as a condition to receiving such benefits under the Policy on behalf of the Covered Person.

SUBROGATION. In the event any payments for benefits provided to a Covered Person are because of an Injury or Sickness caused by a Third Party’s wrongful act or negligence, the Company, to the extent of that payment, will be subrogated to any recovery or right of recovery the Covered Person has against that Third Party, provided:

(a) the Covered Person is entitled to payment for Hospital, surgical or medical services as the result of a Third Party settlement or court judgment; and
(b) such settlement or judgment specified an amount or portion of payment that represents payment for such benefits; and
(c) the Company has paid benefits to the Covered Person under this Policy for the same services or benefits covered by the settlement or judgment.

The Covered Person agrees to make a decision on pursuing a claim against a Third Party within 30 days of the date the Company requires that the Covered Person provide Notice of Claim for the Injury or condition for which benefits under this Policy are sought and to notify the Company of his or her decision within such 30 day period.
SECTION 5 - GENERAL PROVISIONS (continued)

SUBROGATION (Continued)
In the event the Covered Person decides not to pursue payment of claim against such Third Party, the Covered Person:
(a) authorizes the Company to pursue, sue, compromise or settle any such payment of claim in the name of the Covered Person;
(b) authorizes the Company to execute any and all documents necessary; and
(c) agrees to cooperate fully with the Company in the prosecution of any such payment of claim.

If the Company exercises its rights under this provision, it will recover no more than the amount paid under this Policy for such benefits. The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of a Covered Person against any Third Party or coverage.

"Subrogation" means the Company’s right to recover any benefit payments made under this plan:
(a) because of a Sickness or Injury to a Covered Person caused by a Third Party’s wrongful act or negligence; and
(b) which become recoverable from the Third Party or the Third party’s insurer.

The Company’s right of subrogation will not be enforced until the Covered Person has been made whole, as determined by a court of law, as a result of Injury or Sickness.

"Third Party" means any person or organization other than the Company, the Policyholder or the Covered Person.

This provision will not apply if it is prohibited by law.
SECTION 5 - GENERAL PROVISIONS (continued)

COORDINATION OF BENEFITS
This section will be used to determine a Covered Person's benefits under this Policy if:

(1) person is insured for medical care benefits under this Policy and is also covered for these benefits under other plans; and

(2) benefits that would be paid by this Policy, without this section plus the benefits that would be paid by the other plans, without a section similar to this section would exceed Allowed Expenses as defined below.

DEFINITIONS
"Plan" means a plan which provides benefits or services for, or by reason of Hospital, surgical medical, or dental care or treatment through:

1. any other group, blanket or franchise insurance coverage;

2. pre-paid plans for:
   - group Hospital service
   - group medical service
   - group practice
   - individual practice and
   - any other such plans for members of a group;

3. any plan provided by:
   - labor management trusts
   - unions
   - employer organizations
   - professional organization, or
   - employee benefit organizations;

4. a government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965; and

5. any part of a state auto reparation or indemnity act ("no fault insurance") with which the state permits coordination.

"This plan" means the medical care benefits provided by this Policy.

"Allowed Expense" means an Expense which is:
- necessary, Reasonable and Customary;
- incurred while the person for whom the claim is made is insured, or is entitled to benefits after insurance ends, under this Policy;
- at least partly covered under one of the plans covering such person.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room shall not be deemed to be an Allowed Expense unless the patient’s stay in a private room is Medically Necessary in terms of generally accepted medical practice.
SECTION 5 - GENERAL PROVISIONS (continued)

COORDINATION OF BENEFITS (continued)

When this Policy does not pay its benefits first, "Allowed Expense" will not include an Expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an Allowed Expense and a benefit paid.

Effects On Benefits Under This Plan
When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a Policy Year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any Policy Year, the sum of all benefits to be paid to a person (by this and all other plans) equals the Allowed Expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

Rules to Determine which Plan Pays First
A plan, or part of one, that does not have a section similar to this section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be dependent upon the first applicable rule:
I. The plan that does not reserve the right to take this Policy's benefits into account in figuring its own benefits will always be primary.
2. The plan which covers the Covered Person as an employee; rather than as a full or part-time student.
3. If 2 does not apply, the plan which covers the person as a full or part-time student rather than as a Dependent.
4. If 1, 2, and 3 do not apply, the plan which covers the person as a Dependent of the parent whose month and day of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a Dependent of the parent with custody rather than as a Dependent of the parent without custody.

If the parent with custody remarries:
- the plan which covers the child as a Dependent of a parent with custody will pay its benefits first,
- the plan which covers the child as a Dependent of a stepparent will pay its benefits next, and
- the plan which covers the child as a Dependent of a parent without custody will pay its benefits last.
SECTION 5 - GENERAL PROVISIONS (continued)

COORDINATION OF BENEFITS (continued)

For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a student:

(a) when a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent’s plan pays first;
(b) if there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
(c) the plan of the stepparent with custody pays before the plan of the natural parent without custody.

Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3, or 4 will determine which plan pays first.

If none of the above apply, then the plan which has covered the Covered Person for the longer time rather than the shorter time pays first.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

Right to Receive and Release Necessary Information

For this section to work, the Company must exchange information with other plans. To do so, the Company may give to or get from any source all such information it thinks necessary. This will be done without the consent of or notice to any person except as required by the applicable state statute. Any person claiming benefits under this plan must give the Company the information it requires.

Facility of Payment

Another plan may pay a benefit that should be paid by the Company by the terms of the provision. If this happens, the Company may pay to such payer the amount required for it to satisfy the intent of this provision. This will be done at the Company’s discretion. Any amount so paid will be considered a benefit under this plan. The Company will not be liable for such payment after it is made.

Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this Coordination of Benefits provision, it may recover the excess from one or more of:

(a) any person to or for or with respect to whom such payments were made; and
(b) any organization which should have made such payments.
SECTION 6 – COVERAGE DESCRIPTIONS

All coverages of this Policy are shown in the Schedule of Benefits. The coverages are described and governed by the pages attached to and made a part of this Policy.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT and SICKNESS EXPENSE BENEFITS

When, by reason of Injury or Sickness, a Covered Person incurs Eligible Expenses covered by the Comprehensive Accident and Sickness Expense Benefit Provisions which follow, the Company will pay for the Eligible Expense incurred in excess of the Deductible Amount. Benefits are paid in accordance with the allocations shown for the Comprehensive Accident and Sickness Expense Benefits in the Schedule of Benefits. The Company will not pay more than the Maximum Benefit Limit as a result of any one Injury or One Sickness, nor more than the Lifetime Maximum Benefit for all Accidents and Sicknesses combined per lifetime of the Covered Person.

The Maximum Benefit Limit, Lifetime Maximum Benefit and Deductible Amount are shown in the Schedule of Benefits.

Expenses for Elective Treatment or elective surgery will not be covered except as specifically provided elsewhere in this Policy.

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

This provision is subject to all the terms of this Policy.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

After satisfaction of any Deductible Amount, Comprehensive Accident and Sickness Expense Benefits are payable for Eligible Expenses incurred by each Covered Person. Such Eligible Expense must result from Injury or Sickness and must be incurred while the Covered Person is insured for these benefits.

Comprehensive Accident and Sickness Expense Benefits are determined by:
(a) subtracting the applicable Deductible from the Eligible Expense incurred; and
(b) multiplying the result by the Covered Percentage that applies to the Eligible Expense.

The Comprehensive Accident and Sickness Benefits payable will not exceed the Maximum Benefit Limit per Injury or Sickness per Policy Year nor more than the Lifetime Maximum Benefit for all Accidents and Sicknesses combined per lifetime of the Covered Person.

The applicable Deductible Amount(s), Covered Percentage(s), Maximum Benefit Limit and Lifetime Maximum Benefit are shown on the Schedule of Benefits.

Eligible Expenses

Eligible Expenses incurred for services and supplies:
(a) must be Medically Necessary;
(b) must be prescribed or ordered by the attending Doctor; and
(c) will not include amounts in excess of the Reasonable and Customary charge, or the negotiated rate.

An Eligible Expense is incurred on the date the service is performed or the supply is purchased.

Eligible Expenses are charges for:
1. **Hospital Expense** - After satisfaction of the Deductible, Hospital Expenses will be paid as follows:
   Hospital Room and Board Expense – When a Covered Person requires Hospital Confinement, the Company will pay the Covered Percentage of the Hospital room and board expense incurred for the period of such confinement. However, the covered room and board expense does not include any charge in excess of the Daily Room and Board Maximum.

   **Miscellaneous Hospital Expense** - "Miscellaneous Hospital Expense" includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital Expenses.

   The Company will pay the Covered Percentage of the Miscellaneous Hospital Expense incurred by the Covered Person during the period of Hospital Confinement for which Hospital Room and Board benefits are payable.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

Maternity Benefits
When a Covered Person is confined to a Hospital as a resident inpatient for childbirth, the Company will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

(a) 48 hours after a non-cesarean delivery; or
(b) 96 hours after a cesarean section;

for the mother and the newborn infant(s), unless, at the mother’s option, an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. The Company will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Doctor. If such earlier discharge occurs, at least two follow-up visits will be available to the Covered Person.

The first such visit shall occur within 48 hours of discharge. Such visits shall be conducted by a Doctor, a Doctor’s assistant or a registered professional nurse with experience and training in maternal and child health nursing. After conferring with the Covered Person, the health care provider shall determine whether the initial visit will be conducted a home or at the office. Thereafter, he or she shall confer with the Covered Person and determine whether a second visit is appropriate and where it shall be conducted.

Eligible Expenses incurred include, but are not limited to:
(a) parent education;
(b) assistance and training in breast or bottle feeding;
(c) assessment of the home support system;
(d) physical assessment of the newborn; and
(e) the performance of any Medically Necessary and appropriate clinical tests.

Such services shall be consistent with protocols and guidelines developed by national pediatric, obstetric and nursing professional organizations for these services.

2. Surgical Expense - After satisfaction of the Deductible, Surgical Expenses will be paid as follows:
When a Covered Person requires surgery on an inpatient or outpatient basis, the Company will pay the Covered Percentage of the Eligible Expense incurred in connection with such surgery. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

"Surgical Expense" means charges by a Doctor for: (a) a surgical procedure; (b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and c) usual postoperative treatment.

"Surgical procedure" means: (a) a cutting procedure; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor; (f) electrocauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment of hemorrhoids and varicose veins; (i) an operation by means of laser beam; (j) casting; (k) removal of a foreign body; (l) drainage or aspiration; (m) implant; (n) catheter placement; (o) microsurgery.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

Surgical benefits will be equal to the amount determined by multiplying the Eligible Expenses incurred by the Covered Percentage shown in the Schedule of Benefits.

When Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay full value for the most expensive procedure performed and 50% of the value for the second procedure performed. But, the Company will not pay more than the Maximum per Operation.

If, in connection with such surgery, the Covered Person requires the services of an anesthetist, who is not employed or retained by the Hospital in which the surgery is performed, the benefit will be equal to the amount determined by multiplying the Eligible Expense incurred by the Anesthesia Percentage shown in the Schedule of Benefits.

If, in connection with such surgery, the Covered Person requires the services of an Assistant Surgeon, the benefit will be equal to the amount determined by multiplying the Eligible Expense incurred, by the Assistant Surgeon Percentage shown in the Schedule of Benefits.

3. **In-Hospital Doctor’s Fees Expense** – When a Covered Person is confined to a Hospital and requires the services of a Doctor other than a Doctor who performed surgery on, or administered anesthesia to, the Covered Person, the Company will pay the Covered Percentage of the Eligible Expense incurred in excess of the Deductible for such services subject to the Maximum Number of Visits per Day shown in the Schedule of Benefits.

4. **Outpatient Expense** - If a Covered Person requires the use of the services listed in the Schedule of Benefits for this coverage, the Company will pay the Covered Percentage of the Eligible Expenses incurred in excess of the Deductible. The Company will not pay more than the applicable Maximum Benefit shown in the Schedule of Benefits.

5. **Out of Hospital Doctor’s Fees Expense** - Subject to the Exception below: If a Covered Person requires the services of a Doctor while not confined as a resident bed-patient in a Hospital, the Company will pay the Covered Percentage of the Eligible Expenses incurred in excess of the Deductible subject to the Maximum Number of Visits per Day.

   **Exception:** If the services are in connection with surgery and the Doctor is the surgeon who performed the surgery, no benefits are payable under this provision.

6. **Consultant’s Fees** – If a Covered Person requires the services of a Consultant, the Company will pay the Covered Percentage of the Eligible Expense incurred in excess of the Deductible for such services. Such service must be requested and ordered by the attending Doctor.

7. **Ambulance** – When a Covered Person requires the use of a professional ambulance in an emergency, the Company will pay the Covered Percentage of the Eligible Expenses incurred in excess of the Deductible up to the applicable Maximum Amount per Trip.

8. **Dental Treatment (Injury Only)** - If a Covered Person incurs Eligible Expenses for services of a legally qualified dentist or dental surgeon for treatment made necessary by Injury to Sound Natural Teeth in excess of the Deductible Amount, the Company will pay the Covered Percentage of the Eligible Expenses.
9. **Dental Treatment Expense (For Impacted Wisdom Teeth)** – If a Covered Person incurs Eligible Dental Expenses for services of a legally qualified dentist or dental surgeon for removal of one or more impacted wisdom teeth, the Company will pay the Covered Percentage of the Eligible Dental Expenses incurred in excess of the Deductible.

10. **Prescribed Medicines Expense** – If a Covered Person requires medicines, the Company will pay the Covered Percentage of the Eligible Expense incurred by the Covered Person for such medicines that is in excess of the Deductible and Copayment amount per prescription. The medicines must be prescribed by the attending Doctor. This coverage shall also include prescription inhalants required to enable the Covered Person to breathe when suffering from asthma or other life-threatening bronchial ailments and may not be restricted on the number of days before an inhaler refill may be obtained if, contrary to such restrictions, such inhalants have been ordered or prescribed by the treating Doctor and are Medically Necessary.

Eligible Expenses do not include drugs labeled "Caution - limited by Federal Law to investigational use", or any experimental drugs, even though a charge is made.

The Company will not pay more than the Prescribed Medicines Expense Maximum shown in the Schedule of Benefits during any one Policy Year.

11. **Mental and Nervous Disorders Expense:**

**For Hospital Confinement** - When the Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Disorder, the Company will pay the Covered Percentage of Eligible Expense incurred in excess of the Deductible subject to the Maximum Number of Days per Policy Year shown in the Schedule of Benefits.

**For Outpatient Services** - When the Covered Person is not Hospital confined, the Company will pay the Covered Percentage of Eligible Expenses incurred in excess of the Deductible for each session of Outpatient Services subject to the Maximum Number of Visits per Policy Year shown in the Schedule of Benefits.

Definitions:
"Covered Outpatient Services for the Treatment of Mental and Nervous Disorders" means the services furnished by the following: (a) a comprehensive health care service organization; (b) a Hospital; (c) by a facility approved by the State Department of Mental Health which is: (A) a community mental health center; or (B) any other mental health clinic; or (C) an independent clinical social worker; or (D) a clinical specialist in psychiatric and mental health nursing.

12. **Alcoholism and Substance Abuse Expense** - If, by reason of alcoholism or alcohol abuse, substance abuse or substance dependency a Covered Person requires treatment, the Company will pay benefits for the inpatient Eligible Expenses incurred at a Hospital or Residential Treatment Facility, or Intermediate Care Facility for the Medically Necessary treatments subject to the following limits:

**Inpatient Treatment** - When the Covered Person is confined as an inpatient, the Company will pay the Covered Percentage of the Eligible Expenses incurred in excess of the Deductible, limited to: 30 days of inpatient rehabilitation services in any Policy Year.
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"Residential Treatment Facility" means a facility which provides 24 hour treatment for people with drug abuse, alcohol abuse on an inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services. The Company will recognize a Residential Treatment Facility if it’s accredited for its stated purpose by the Joint Commission, and carries out its stated purpose in compliance with all relevant state and local laws.

“Intermediate Care Facility” means a facility which provides for the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, any of the following therapeutic techniques, as identified in a treatment for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs: (a) chemotherapy; (b) counseling; (c) detoxification services; (d) other ancillary services, such as medical testing, diagnostic evaluation and referral to other services identified in the treatment plan.

Outpatient Treatment - When the Covered Person is not Hospital Confined, the Company will pay the Covered Percentage of Eligible Expenses incurred in excess of the Deductible for each session of covered Outpatient services up to a maximum of 30 visits per Policy Year for outpatient treatment services.

Outpatient services consisting of consultant or treatment sessions will not be payable unless these services are furnished by a Doctor or a psychotherapist who is licensed by the state in which he or she practices.

Outpatient coverage is limited to one outpatient visit per day.

13. Diabetes Expense – If a Covered Person incurs Eligible Expenses for the following equipment and supplies for the treatment of diabetes, the Company will pay the Covered Percentage of the Eligible Expenses Incurred in excess of the Deductible. Such equipment and supplies must be recommended in writing or prescribed by a Doctor. Benefits will be paid for Eligible Expenses on the same basis as any other Sickness according to the limits and maximums in the Schedule of Benefits.

The Eligible Expenses include but are not limited to the following equipment and supplies: (a) lancets and automatic lancing devices; (b) glucose test strips; (c) blood glucose monitors; (d) blood glucose monitors for the visually impaired; (e) control solutions used in blood glucose monitors; (f) diabetes data management systems for management of blood glucose; (g) urine testing products for glucose and ketones; (h) oral anti-diabetic agents used to reduce blood sugar levels; (i) alcohol swabs; (j) syringes; (k) injection aids including insulin drawing up devices for the visually impaired; (l) cartridges for the visually impaired; (m) disposable insulin cartridges and pen cartridges; (n) all insulin preparations; (o) insulin pumps and equipment for the use of the pump including batteries; (p) insulin infusion devices; (q) oral agents for treating hypoglycemia such as glucose tablets and gels; (r) glucagon for injection to increase blood glucose concentration.

Coverage is also provided for Medically Necessary diabetes self-management education and education relating to diet. Such education may be provided by a Doctor or the Doctor's staff as a part of an office visit. Such education when provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a Doctor may be provided in a group setting. When Medically Necessary, self management education and diet education shall also include home visits.
14. **Prescribed Contraceptive Expense** - Benefits are payable for Eligible Expenses incurred for prescription contraceptive drugs and devices. The charges must be incurred while a Covered Person is insured for these benefits. If Prescribed Medicine Expense coverage is included in this Policy, the benefits payable under this coverage will be the same as those paid for prescription medicine under the Prescribed Medicine Expense, subject to the same limits, deductibles, and maximums under that coverage. The Company will pay the Eligible Expenses incurred for prescription contraceptive drugs and devices approved by the U.S. Food and Drug Administration (FDA) on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

15. **Mammography and Cervical Cytological Screening Expense** - Benefits are payable for Eligible Expenses incurred by a female Covered Person for cervical cytology screening and low-dose mammograms. The Company will pay the Expenses on the basis as any other Sickness according to the limits and maximums in the Schedule of Benefits. The Expenses must be incurred while a Covered Person is insured for these benefits.

Benefits will be paid for Expenses incurred for the following:

(a) In the case of benefits for cervical cytology screening, an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a Doctor, which examination may be made once a year or more if ordered by the Doctor.

(b) In the case of mammograms:

   (1) one baseline mammogram for women at least age 35 but less than 40;
   (2) one mammogram every two years for women age 40 but less than 50;
   (3) a mammogram every year for women who are at least 50 years of age; and
   (4) when ordered by a Doctor for women who are at risk for breast cancer.

A woman may be deemed at risk for breast cancer because of (a) a personal or family history of breast cancer, or (b) having a history of biopsy-proven benign breast disease, or (c) having a mother, grandmother, sister or daughter who has or has had breast cancer, or (d) not having given birth before age 30.

“Mammogram” means any low-dose radiologic screening procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Human Resources dedicated specifically for mammography and includes a Doctor’s interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology. The facility in which the mammogram is performed must meet accreditation standards established by the American College of Radiology or equivalent standards established by the State of Georgia.

16. **Breast Cancer Treatment Expense** - Benefits are payable for Eligible Expenses for a lymph node dissection or a lumpectomy or a mastectomy for the treatment of breast cancer on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The charges must be incurred while a Covered Person is insured for these benefits.

Benefits are also payable for such number of visits following Hospital Confinement as determined to be appropriate by the attending Doctor, Doctor’s assistant or a registered professional nurse with experience and training in post-surgical care, after consultation with the Covered Person. Such services may be rendered in the Covered Person’s home or in the attending Doctor’s office.
17. **Reconstructive Breast Surgery** - Benefits are payable for Eligible Expenses incurred for breast reconstructive surgery after a mastectomy performed while a Covered Person under this Policy. This provision includes coverage for: (a) all stages of reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas; and (d) at least two external postoperative prostheses incidental to the covered mastectomy. Benefits provided under this provision will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

18. **Prostate Cancer Screening Expense** - Benefits are payable for Eligible Expenses incurred by a male Covered Person who is 45 years old or older for an annual prostate cancer screening, commonly known as a prostate specific antigen (PSA) test. Such test shall also be covered for a male Covered Person who is 40 years of age or older if ordered by the attending Doctor. The charges must be incurred while the Covered Person is insured for these benefits. Benefits provided under this provision will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

19. **Temporomandibular Joint Dysfunction Expense** - Benefits are payable for Eligible Expenses incurred for surgical or non-surgical treatment by a Doctor professionally qualified by training and experience for the correction of temporomandibular joint dysfunction or for the correction of functional deformities of the maxilla and mandible. The charges must be incurred while a Covered Person is insured for these benefits. The Company will pay benefits on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits but in no event will the maximum lifetime benefit be less than $2,500.

"Functional deformity" means a deformity of the bone or joint structure of the maxilla or mandible such that the normal character and essential function of such bone structure is impeded.

"Temporomandibular joint" means the connection of the mandible and the temporal bone through the articular disc surrounded by the joint capsule and associated ligaments and tendons.

"Temporomandibular dysfunction" means congenital or developed anomalies of the temporomandibular joint.

20. **Chlamydia Screening Test Expense** - Benefits are payable for Eligible Expenses for chlamydia screening tests on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while a Covered Person is insured for these benefits. The Company will pay a benefit for such Eligible Expenses in connection with one annual chlamydia screening test for a female Covered Person who is under 29 years of age.

21. **Drug Treatment of Children’s Cancer Expense** - Benefits are payable for an approved Phase I and III prescription drug clinical trial program, as approved by the Federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in a covered Dependent child under the age of 19. The Eligible Expenses must be incurred while a Covered Person is insured for these benefits. The Company will pay benefits for such Eligible Expenses in connection with one approved program: (a) tests new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children; (b) introduces a new therapy or regimen to treat recurrent cancer in children; or (c) seeks to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens; and
(d) has been certified by and utilizes the standards for acceptable protocols established by the:
(1) Pediatric Oncology Group; (2) Children's Cancer Group; or (3) The laws, rules or regulations of the
jurisdiction in which this Policy is issued governing this coverage and its compliance with any applicable
requirements.

Benefits are payable for Routine Patient Care Costs incurred by a Covered Dependent child under an
approved clinical trial program for the treatment of children's cancer.

**Routine Patient Care Costs** mean those Medically Necessary costs of blood tests, X-rays, bone
scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally
incurred by the covered Dependent child in connection with the provision of goods, services or benefits
of children under an approved clinical trial program for treatment of children's cancer which otherwise
would be covered under the Policy if such Medically Necessary costs were not incurred in connection
with an approved clinical trial program for treatment of children's cancer.

Charges for services and treatment not covered under this benefit are as follows:
(a) investigational items or service itself;
(b) items and services provided solely to satisfy data collection and analysis needs and that are not
used in the direct clinical management of the covered Dependent child; and
(c) costs of any clinical trial therapies, regimens, or combination thereof, any drugs or
pharmaceuticals;
(d) costs associated with the provision of any goods, services or benefits to a covered Dependent
child in connection such an approved clinical trial program for treatment of children's cancer;
(e) any additional costs associated with the provision of any goods, services or benefits which
previously have been provided to the covered Dependent child, paid for or reimbursed, or any
other similar costs.

Benefits provided under this coverage will be paid on the same basis as any other Sickness according
to the limits and maximums shown in the Schedule of Benefits.

22. **Dental Anesthesia Expense** - Benefits are payable for Eligible Expenses incurred by a Covered
Person for general anesthesia and associated hospital or ambulatory surgical facility charges in
connection with dental care. The Eligible Expenses must be incurred while the Covered Person is
insured for these benefits. The Covered Person must be: (a) seven years of age or younger or
developmentally disabled; (b) an individual for whom a successful result cannot be expected from
dental care provided under local anesthesia because of a neurological or other medically compromising
condition; or (c) an individual who has sustained extensive facial or dental trauma, unless otherwise
covered by Workers' Compensation insurance.

Benefits provided under this provision will be paid on the same basis as any other Sickness according
to the limits and maximums shown in the Schedule of Benefits.

23. **Autism Expense** - Benefits are payable for Eligible Expenses incurred by a Covered Person for the
treatment of autism on the same basis as for any other Sickness according to the limits and maximums
shown in the Schedule of Benefits. The charges must be incurred while the Covered Person is insured
for these benefits.

“Autism” means a developmental neurological disorder, usually appearing in the first three years of life,
which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely
impaired social interaction and communication skills.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

The Deductible
The Deductible Amount(s) applies to each Covered Person once each Policy Year. It is the dollar amount of Eligible Expense for which no benefits are payable. The amount of and types of Eligible Expense subject to the Deductible Amount(s) are shown on the Schedule of Benefits.

Family Deductible
If, in any Policy Year, the sum of Eligible Expense used toward the individual Deductibles of each of three Covered Persons who are members of a Covered Student’s family equals the Family Deductible shown on the Schedule of Benefits, the Deductible Amount will be deemed to be met with respect to Eligible medical Expense incurred by such Covered Persons for the rest of that Policy Year.

Out-of-Pocket Limit
This is a benefit that will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable reaches the amount(s) shown in the Schedule of Benefits due to: (1) the Deductible(s); and/or (2) Covered Percentages less than 100%.

When this benefit becomes applicable to a Covered Person during a Policy Year, Covered Percentages are raised. They are raised to 100% for all Eligible Expenses incurred by the Covered Person in the remainder of that year. The Out-of-Pocket Limit is shown in the Schedule of Benefits.

Family Out-of-Pocket Limit
If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of each of three Covered Persons who are members of a Covered Student family equals the Family Out-of-Pocket Limit the Covered Percentages are raised. They are raised for all Eligible Expenses incurred by any Covered Person who is a member of the Covered Student’s family for the remainder of that year. The Family Out-of-Pocket Limit is shown in the Schedule of Benefits.

Maximum Benefit
The Maximum Benefit Limit applies to each Covered Person for each Injury or Sickness. It is the total of benefits payable for Eligible Expenses incurred during the Policy Year for that Injury or Sickness. It is shown in the Schedule of Benefits.

The Lifetime Maximum Benefit applies to each Covered Person for all Accidents and Sicknesses combined. It is the total of benefits payable for all Eligible Expenses incurred during the lifetime of the Covered Person.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

REPATRIATION OF REMAINS EXPENSE

Repatriation of Remains Benefit. If a Covered Person suffers loss of life due to Injury or Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, 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.

AIG 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 AIG Assist in advance.

In addition to the Exclusions in the Exclusions and Limitations section of the Policy, Repatriation of Remains benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Covered Person is entitled to benefits under any Workers’ Compensation Act or similar law.
INSURANCE PROVISIONS CONCERNING
COMPREHENSIVE ACCIDENT AND SICKNESS EXPENSE BENEFIT

MEDICAL EVACUATION EXPENSE
The Company will pay, subject to the limitations set out herein, for Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Sickness that warrants his or her Medical Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all Sicknesses from the same or related causes.

The Doctor ordering the Medical Evacuation must certify that the severity of the Covered Person's Injury or Sickness warrants his or her Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

AIG Assist must make all arrangements and must authorize all expenses in advance for any Medical Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact AIG Assist in advance.

Eligible Medical Evacuation Expense(s) means an expense that: (1) is charged for a Medically Necessary Medical Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Medical Evacuation means, if warranted by the severity of the Covered Person’s Injury or Sickness: (1) the Covered Person’s immediate Transportation from the place where he or she suffers an Injury or Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Covered Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness and being treated at a local hospital or other medical facility; or (3) both (1) and (2) above. A Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary Medical Evacuation Service means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Medical Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Doctor and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Covered Person.

Transportation means moving the Covered Person during a Medical Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.
SECTION 7 - EXCLUSIONS AND LIMITATIONS

This 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 and for extraction of impacted wisdom teeth.

2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service fee.

3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such; radial keratotomy; or treatment for visual defects and problems. “Visual defects” means any physical defect of the eye which does or can impair normal vision apart from the disease process. Eye refraction is not covered except when due to a disease process or as specifically provided in this Policy.

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. for Injury or Sickness resulting from war or act of war, declared or undeclared.

6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.

7. 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.

8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.

9. 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 reconstructive surgery after a mastectomy.

10. for preventive medicines, serums, vaccines, except as specifically provided in this Policy.

11. as a result of committing or attempting to commit an assault or felony or participation in a riot, illegal occupation or insurrection.

12. for Elective Treatment or elective surgery unless otherwise provided in this Policy.

13. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

14. for any services rendered by a Covered Person's Immediate Family Member.

15. for a treatment, service or supply which is not Medically Necessary.

16. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury. This exclusion does not apply to Medical Evacuation Expense or Repatriation of Remains Expense.

17. for Injury caused by, contributed to or resulting from the Covered Person'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 Covered Person's Doctor. This exclusion does not apply to Medical Evacuation Expense or Repatriation of Remains Expense.
SECTION 7 - EXCLUSIONS AND LIMITATIONS (continued)

18. for surgery and/or treatment of: acne; acupuncture; gynecomastia; allergy testing; biofeedback-type services; circumcision; corns, calluses and bunions, except capsular or bone surgery; deviated nasal septum, including submucuous resection and/or other surgical correction thereof; hair growth or removal; hair transplants; impotence, organic or otherwise; nonmalignant warts, moles and lesions; premarital examinations; sexual reassignment surgery; sleep disorders, including supplies, treatment and testing thereof; tubal ligation; vasectomy; alopecia; and weight reduction.

19. for routine physical examinations and routine testing, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy.

20. for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purposes of removing nerve interference as a result of or related to distortion, misalignment or subluxation of or in the vertebral column except as specifically provided.

21. for addiction and co-dependency services and supplies related to nicotine addiction.

22. for patient controlled analgesia (PCA).

23. for treatment of infertility (male or female), including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted conception, elective sterilization or its reversal, artificial insemination or in vitro fertilization.

24. for organ transplants.

25. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate and professional sports contest, competition or activity, including travel to and from the activity and practice, sporting events, racing or speed contests; while participating in any practice or conditioning program for such sport, contest or competition; hang gliding; parasailing; sky diving; glider flying; sail planing; parachuting; or bungee jumping.

26. for weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment of obesity, surgery for removal of excess skin or fat.

27. for breast reconstruction and implantation or removal of breast prostheses unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.

28. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.

29. for hospice or home health care.

PRE-EXISTING CONDITIONS: Pre-existing Conditions are not covered for the first 12 months following a Covered Person’s effective date of coverage under this Policy. This limitation will not apply if:

(a) the Covered Person has been covered under the Policyholder's prior Policy for more than 12 consecutive 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 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.
SECTION 7 - EXCLUSIONS AND LIMITATIONS (continued)

Pre-existing Conditions do not apply to:
(a) a newborn Dependent child; or
(b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under this Policy.

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

Creditable Coverage means coverage under any of the following:
(a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
(b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
(c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
(e) a medical care program of the Indian Health Service or of a tribal organization;
(f) a state health benefits risk pool;
(g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
(h) a public health plan as defined by federal regulations; or
(i) a health benefit plan under section 5(e) of the Peace Corps Act.
DOMESTIC PARTNER ELIGIBILITY RIDER

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy’s Application. It applies only with respect to accidents or sicknesses that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider.

DEFINITIONS

The following is added to the definition of Dependent as specified in the Policy or Certificate.

"Dependent" also means:

(a) the Covered Student's same sex or opposite sex domestic partner provided they are living together and a written declaration of domestic partnership acceptable to the Company has been completed and/or any applicable requirements of the state, city and/or country in which they reside regarding domestic partnership have been met; and

(b) the Covered Student's domestic partner's unmarried child under age 19. An unmarried child age 19 but less than 25 is a dependent if he is:
   (1) dependent upon the Covered Student or the Covered Student's domestic partner for support; and
   (2) living in the household of the Covered Student or the Covered Student's domestic partner; or
   (3) a full-time student for five months or more at an accredited institution of higher learning in each calendar year since reaching age 19.

The term "child" includes a Covered Student’s and/or domestic partner’s:

(a) legally adopted child;
(b) child who has been placed in the Covered Student’s and domestic partner’s home pending adoption procedures; and
(c) step-child and natural child if such child resides with the Covered Student and domestic partner and depends on the Covered Student and/or domestic partner for full support.

TERMINATION OF DEPENDENT COVERAGE

The following is added to the Termination of Dependent Coverage portion of the Termination of Coverage, Extension of Benefits section of the Policy or Certificate.
Insurance for Dependents will also terminate on the first premium due date after any of the following events occur:

(a) For the domestic partner,
   (1) the Covered Student or domestic partner sends the other a notice for ending the domestic partnership;
   (2) the Covered Student or domestic partner gets married to another person;
   (3) the Covered Student and domestic partner stop living together.
   (4) Dependent insurance is deleted from this Policy (any unearned premium will be refunded on a pro rata basis); or
   (5) at the end of the last period for which any required premium has been paid.

(b) For a child of the domestic partner,
   (1) status as a Dependent ends;
   (2) the date the domestic partner no longer qualifies as a Dependent;
   (3) Dependent insurance is deleted from this Policy (any unearned premium will be refunded on a pro rata basis); or
   (4) at the end of the last period for which any required premium has been paid.

NOTE: The Covered Student must notify the Company within 30 days if there is any change in the status between the Covered Student and domestic partner as domestic partners. A signed statement of termination of domestic partnership will be required.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

For purposes of this provision, the following definition applies:

"Living Together" means that both parties share a place to live.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider: