

BLANKET STUDENT ACCIDENT & SICKNESS POLICY



Combined Insurance Company of America
A Legal Reserve Stock Corporation

(herein called the "Company")

Home Office: 5050 Broadway, Chicago, Illinois 60640

Administrative Office: 331 Newman Springs Road, Suite 133, Red Bank, NJ 07701

Combined Insurance Company of America agrees to provide the benefits shown in the Plan of Insurance with respect to each person insured for them under this Policy. The benefits will be paid in accordance with the provisions of this Policy.

This Policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums as set forth herein.

This Policy takes effect as of 12:01 AM Central Standard Time on its Policy Effective Date. This Policy ends as of 12:01 AM Central Standard Time, on its Policy Termination Date. These dates are shown in the Plan of Insurance.

The provisions on the pages which follow form a part of this Policy. This Policy is issued at the Administrative Office of Combined Insurance Company of America in New Jersey on **March 1, 2009**.

This Insurance Policy Number **CUH201629** is issued to **Purdue University**.
(the Policyholder)

For Combined Insurance Company of America

Chairman and
Chief Executive Officer

Secretary

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SECTION I - PLAN OF INSURANCE

INDEMNITY PLAN DESIGN

Policyholder: Purdue University
Policy Number: CUH201629
Policy Effective Date: March 1, 2009
Policy Termination Date: March 1, 2010

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil".

Lifetime Maximum Benefit:
Per Insured Person: \$ 100,000
Deductible per Policy Year: \$ 0.00 per Insured Person

COVERAGE **BENEFIT AMOUNT**

HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage: 100% of R & C
Miscellaneous Hospital Expense Covered Percentage: 100% of R & C

SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Surgery Expense Covered Percentage: 100% of R & C
Anesthesia Expense Covered Percentage: 100% of R & C

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

Covered Percentage: 100% of R & C

OUTPATIENT EXPENSE BENEFIT

Doctor's Office Visit Expense Covered Percentage: 100% of R & C
Chiropractic Care Office Visit Expense Covered Percentage: 100% of R & C
Chiropractic Care Office Visit Expense Benefit Maximum: \$50 per visit
\$500 / 10 visits per Injury or Sickness

Hospital Outpatient Department
Expense Covered Percentage: 100% of R & C
Emergency Room Expense Covered Percentage: 100% of R & C
Diagnostic X-ray and Laboratory Testing
Expense Covered Percentage: 100% of R & C
Physical Therapy Expense Covered Percentage: 100% of R & C
Benefit Maximum: \$500 per Policy Year
Post-Surgical Physical Therapy Expense Benefit Maximum: 100% of R & C
\$500 per Policy Year
Occupational Therapy Expense Covered Percentage: 100% of R&C
Benefit Maximum: \$500 per Policy Year
Acupuncture Expense Benefit Maximum: 100% of R&C
Benefit Maximum: \$500 per Policy Year

COVERAGE **BENEFIT AMOUNT**

Immunization Expense Covered Percentage: Nil
High Cost Procedures Expense Covered Percentage: 100% of R & C

MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT

Inpatient Expense Covered Percentage: 100% of R & C
Inpatient Expense Benefit Maximum: \$10,000 per Lifetime
Outpatient Expense Covered Percentage: 100% of R & C
Outpatient Expense Benefit Maximum: \$500 per Lifetime

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum: \$10,000

ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage: 100% of R & C

AMBULANCE EXPENSE BENEFIT

Covered Percentage: 100% of R & C

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage: 100% of R & C

PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage: 100% of R & C

PRESCRIPTION DRUG EXPENSE BENEFIT

Covered Percentage: 100% of R & C
Benefit Maximum: \$2,500 per Policy Year

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

Covered Percentage: 100% of actual Expense
Benefit Maximum: \$100,000

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage: 100% of actual Expense
Benefit Maximum: \$50,000

DIABETES EXPENSE BENEFIT

Covered Percentage: 100% of R & C

BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT

Covered Percentage: 100% of R & C

COLORECTAL CANCER SCREENING EXPENSE BENEFIT

Covered Percentage: 100% of R & C

PERVASIVE DEVELOPMENTAL DISORDERS EXPENSE BENEFIT

Covered Percentage: 100% of R & C

Underwriting Notes

1. Emergency Medical Reunion – This benefit is provided by On-Call International in connection with coverage under this plan, of up to \$3,000 at \$100 per day, when an Insured Person is hospitalized for more than 6 days, and will arrange and pay for round trip economy-class transportation for one individual selected by the Insured Person, from the Insured Person's current Home Country to the location where the Insured Person is hospitalized. The benefits will include Airfare, hotel and meals to a maximum of \$100 per day up to the maximum stated in the Schedule of Benefits above.
2. The term "Insured Person" includes any faculty or staff while insured under this policy.
3. The term "Insured Student" means an outbound student, faculty, staff, scholar, or other persons of similar description who are U.S. Citizens, permanent residents of the U.S., or Non-U.S. citizens traveling outside the U.S. with a current passport or visa to participate in studies, official business or research assignments sponsored by the University.
4. The term "Eligible Student", as defined on page 6, includes each of the classes as defined under "Insured Student".

SECTION II - SCHEDULE OF ELIGIBLE CLASSES

<u>CLASS</u>	<u>DESCRIPTION OF CLASS</u>
I.	Any outbound student and visiting faculty, staff, scholar, or other persons of similar description who are U.S. Citizens or U.S. resident aliens traveling outside the U.S. with a current passport or visa to participate in studies, official business or research assignments sponsored by the University.
II.	Any outbound student and visiting faculty, staff, scholar, or other persons of similar description who are or non-U.S. citizens or non-U.S. resident aliens with a current passport or visa, studying at a school, college or university, and traveling outside the U.S. to participate in a sponsored Study Abroad program.
III.	Any faculty or staff traveling outside the United States to participate in research assignments sponsored by the University, or on official business of the University.

An Eligible Student must also meet all of the following:

1. is enrolled and actively engaged, as defined by the Policyholder in accordance with applicable United States law, in educational activities;
2. is temporarily outside his/her home country or country of regular domicile as a non-resident alien or a non-domiciled United States citizen with dual citizenship;
3. has a current passport and applicable current student visa or other non-immigrant visa which allows the individual to enroll in a course of study (non-domiciled United States citizen-passport only); and
4. maintains non-immigrant status under the applicable visa type according to the applicable United States law.

The following do not count toward fulfilling the Eligibility requirement:

- Home Study
- Correspondence courses
- Internet courses
- Television courses

- III. Dependents of: any outbound student and visiting faculty, scholar, or other persons of similar description who are: (i) Eligible Student's lawful spouse or same sex domestic partner or unmarried Child under age 19 and dependent upon the Eligible Student or the student's spouse for the Child's main support and care (the child does not have to reside with its parent(s) or be in the provider services area); (ii) enrolled for coverage under the Policy at the same time the Eligible Student enrolls; (iii) U.S. Citizens or U.S. resident aliens traveling outside the U.S. with a current passport or visa; or (iv) temporarily outside the dependent's home country or country of regular domicile as a nonresident alien, or a non-domiciled United States citizen with dual citizenship.

SECTION III - SCHEDULE OF PREMIUM RATES

<u>CLASS OF INSURED PERSONS</u>	<u>TERM OF COVERAGE</u>	<u>PREMIUM RATE</u>
Student Only	Monthly	\$ 32.00
Faculty/Staff	Monthly	\$ 38.60
Spouse	Monthly	
Age <25		\$ 43.00
Age 25 – 29		\$ 49.00
Age 30 – 39		\$ 59.00
Age 40 – 49		\$ 81.00
Age 50 – 59		\$ 101.00
Age >60		\$ 113.00
Each Child	Monthly	\$38.00

* Month is defined as up to and including 35 consecutive days (5 weeks). Any trip 36 – 70 days will be charged two months.

SECTION IV - DEFINITIONS

Whenever used in this Policy:

"Accident" means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

"Benefit Period" means the 12 months immediately following the date of the Accident or first treatment of a Sickness.

"Coinsurance" means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

"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; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

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

"Co-payment" means the specified dollar amount an Insured Person must pay for specified charges. The co-payment is separate from and not a part of the Deductible or Coinsurance.

"Covered Charge" or "Expense" as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

"Covered Percentage" means that part of the Covered Charge that is payable by the Company after the Deductible or Co-payment has been met.

"Deductible" means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

"Dependent" means: (a) the Insured Student's spouse or domestic partner; or (b) the Insured Student's unmarried Children under the age of nineteen years. Children must be fully supported by the Insured Student. Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage shall include, but not be limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate. We cover the newborn child for dependent benefits from and after the moment of birth. We cover any minor child placed with an Insured Student for adoption for dependent benefits from and after the earlier of the date the child is placed in the physical custody of the Insured Student for purposes of adoption or the date of the entry of an order granting the Insured Student custody of the child for purposes of adoption. To continue the newborn or adopted child's dependent benefits past the first 31 days, the Insured Student must notify Us in writing within 31 days of the child's birth or adoption. Such newly adopted children are exempt from any Pre-Existing Conditions Limitation when enrolled in this manner.

The term "children" includes an Insured Student's biological children; step-children; adopted children (as described above) and who depend on the Insured Student for their full support.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured Student must send us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

"Doctor" as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (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 residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

"Domestic Partner" means the same sex partner of an Insured Student who has filed a "Declaration of Domestic Partnership" with the Policyholder's administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.

"Domestic Student" is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

"Effective Date" means the first date an eligible person becomes covered under the Policy.

"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 Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.

"Experimental or Investigational Care" means a service or supply:

- (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
- (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

"Hospital" means a facility which meets all of these tests:

- (a) it provides inpatient 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.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

"Hospital Confinement" means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

"Injury" means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

"Insured Person" means an Insured Student and his or her covered Dependent(s) while insured under this Policy.

"Insured Student" means a student of the Policyholder who is eligible and insured for coverage under this Policy.

"International Student" is a student classified as a Non-Immigrant. For example, students holding visa types: "F" (Student), "J" (Exchange Visitor), "B" (Tourist), or "A" (Diplomat).

"Lifetime Aggregate Maximum" means the total amount of benefits payable for all Injuries and Sicknesses combined under this Student Health Insurance Policy or Policies issued to the Policyholder immediately before this Policy.

"Loss" means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

"Medical Emergency" means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

"Medically Necessary" means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Insured Person or provider;
- (b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms;
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or 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.

"Policy Effective Date" means the date the Policy takes effect as shown in the Plan of Insurance.

"Policy Termination Date" means the date the Policy ends as shown in the Plan of Insurance.

"Policyholder" means the institution indicated on the face page of this Policy.

"Policy Year" means the 12 month period beginning on the Policy Effective Date.

"Reasonable and Customary Expenses" means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

"Sickness" means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

"We", "Us" and "Our" means the Combined Insurance Company of America.

"You" and "Your" means the Policyholder.

SECTION V - EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL

This Policy takes effect as of the Policy Effective Date stated in the Plan of Insurance. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided in the General Provisions Section, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on the first anniversary of the Policy Effective Date. We will give the Policyholder at least sixty days prior written notice. We also reserve the right to refuse to renew this Policy.

However, in no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.

SECTION VI- EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE

EFFECTIVE DATE OF INSURED PERSON'S COVERAGE

The insurance of each Eligible Student shall take effect as follows:

- (a) If an Eligible Student enrolls and pays the premium on or before the Policy Effective Date, coverage will begin on the Policy Effective date;

TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates:

- (a) on the date this Policy is terminated; or
- (b) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error; or
- (c) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person; or
- (d) on the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes; or
- (e) on the last day the Insured Student is required to be on campus at the Policyholder or, if the Policyholder has so elected, the anniversary of the Policyholder's Policy.

Termination of Insurance for an Insured Person shall be without prejudice to any claim which starts prior thereto.

If a student loses eligibility under this Policy because he or she no longer qualifies under the terms described in the Master Policy, he or she may apply for continuation of coverage. The application must be made within 31 days of losing eligibility, and the applicable premium must be paid.

SECTION VII – RENEWABILITY OF COVERAGE

A student who is enrolled as a regular undergraduate or graduate student at the College or University will be provided with continuous coverage under this Policy for himself or herself and his or her Insured Dependents each subsequent year the Policyholder renews this Policy with Us. Once an Insured Person has been covered under this Policy and satisfied any Pre-existing Condition Limitation exclusion period, if applicable, coverage under this Policy will be considered continuous. The student must apply for coverage and pay premiums as described in the Policy.

SECTION VIII - PRE-EXISTING CONDITIONS LIMITATION

"Pre-existing Condition" is a Sickness, Injury, or related condition which was contracted or which manifested itself, or for which a licensed Doctor was consulted; or for which treatment or medication was prescribed within six (6) months prior to the Effective Date of the Insured Person's coverage under this Policy.

The Pre-existing Condition Waiting Period is six (6) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a six (6) consecutive month period has passed from the Insured Student's effective date, and (b) We will pay only for Loss or expense incurred after such six (6) consecutive month period.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage, the Pre-existing Condition Waiting Period will have to be satisfied again.

SECTION IX - CONTINUOUS INSURANCE

This Policy may be replacing a Prior Plan with another insurer.

Prior Plan means the Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy.

"Injury" or "Sickness" shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the Lifetime Aggregate Maximum.

Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.

DEDUCTIBLE, COINSURANCE AND COPAYMENT RULES

DEDUCTIBLE The Insured Person's Deductible applies to all Covered Charges unless specified otherwise in this Policy.

Common Accident - If two or more family members are hurt in the same Accident, only one Deductible needs to be satisfied among them for Expenses relating to the Accident. This special feature applies to eligible Expenses each Policy Year for the same Accident.

COINSURANCE/COPAYMENTS Some covered services are subject to Coinsurance and Co-payments. This is the amount the Insured Person must pay to the Doctor or Hospital for each procedure, visit or confinement each time he or she receives a covered service, including prescription drugs. The Coinsurance is not applied until after the Insured Person has paid any applicable Deductible that may be required under this Policy. What We pay is shown in the Plan of Insurance. The Coinsurance and Co-payments, whether from a Network or a Non-Network Provider, apply toward the Out-of-Pocket Maximum.

Covered services which are rendered by a Network Provider and subject to a Co-payment will not be subject to the Deductible.

WAIVER OF COPAYMENT The Emergency Room Co-payment will be waived if the Insured Person is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured Person received Medical Emergency care.

SECTION XI - COVERAGE

All benefits to this Policy are shown in the Plan of Insurance. The benefits are described on the pages attached to and made a part of this Policy.

ACCIDENT EXPENSE BENEFIT

When, by reason of Injury, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay the Covered Percentage of the Covered Charges incurred within 52 weeks from the date of Accident as shown in the Plan of Insurance. Benefits are paid in accordance with the schedule shown for the Accident Expense Benefits in the Plan of Insurance. When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth, We will pay for the Covered Percentage of the Covered Charges incurred within 52 weeks from the date of Accident as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

SICKNESS EXPENSE BENEFIT

When, by reason of Sickness, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay for the Covered Percentage of the Covered Charges covered by the Sickness Expense Benefit Provisions incurred within 52 weeks from the date of the first medical treatment for the Sickness as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Charges that are not covered for Accident & Sickness Expense Benefits

Charges to buy or rent:

- Air conditioners;
- Air purifiers;
- Motorized transportation equipment;
- Escalators or elevators in private homes;
- Eye glass frames or lenses, hearing aids;
- Swimming pools or supplies for them;
- General exercise equipment.

HOSPITAL EXPENSE BENEFIT

Part A Hospital Room and Board Expense

When, by reason of Injury or Sickness, an Insured Person requires Hospital Confinement, We will pay the Covered Percentage of the Hospital room and board Covered Charge for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a newborn nursery, special care, or intensive care unit.

Part B Miscellaneous Hospital Expense

Miscellaneous Hospital Expense includes expenses incurred for:

- (a) anesthesia, anesthesia supplies and services;
- (b) operating, delivery and treatment rooms and equipment;
- (c) diagnostic x-ray and laboratory tests;
- (d) lab studies;
- (e) oxygen tent;
- (f) blood and blood services;
- (g) prescribed drugs and medicines;
- (h) medical and surgical dressings, supplies, casts and splints;
- (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;
- (j) chemotherapy treatment with radioactive substances;
- (k) intravenous injections and solutions, and their administration;
- (l) physical and occupational therapy; and
- (m) other necessary and prescribed Hospital expenses.

We will pay the Covered Percentage of the Covered Charge incurred by the Insured Person during the period of Hospital Confinement or for a Surgical Procedure performed on an outpatient basis.

What We pay is shown in the Plan of Insurance.

SURGICAL EXPENSE BENEFIT

Part A Surgery Expense Benefit

When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Charges of the Surgical Expense, in connection with any one Surgical Procedure, subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Definitions

"Surgical Expense" means charges by a Doctor for:

- (a) a Surgical Procedure;
- (b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and
- (c) usual post-operative 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;
- (f) electrocauterization;
- (g) diagnostic and therapeutic endoscopic procedures;
- (h) injection treatment for hemorrhoids and varicose veins;
- (i) an operation by means of a laser beam.

Part C Anesthesia Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the Expenses incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Percentage of the Covered Charge incurred for such services, subject to the Deductible shown in the Plan of Insurance.

The following medical services performed by a Doctor are covered on an inpatient basis:

- (a) one Doctor visit per day;
- (b) constant care and treatment while an Insured Person is confined in an intensive care unit;
- (c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors;
- (d) consultation by another Doctor when requested by the Insured Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.

What We pay is shown in the Plan of Insurance.

OUTPATIENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility, or other similar facility licensed by the state, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Outpatient Services

Covered Charges for "Outpatient Services" include the following services:

- (a) a Doctor's office while not Hospital Confined;
- (b) chiropractic care up to the maximum shown in the Plan of Insurance;
- (c) a Hospital outpatient department or emergency room;
- (d) diagnostic x-ray and laboratory testing;
- (e) blood and blood services, if provided and billed by a Hospital or other facility;
- (f) physical and occupational therapy as shown in the Plan of Insurance;
- (g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;
- (h) radiological lab or other similar facility licensed by the state;
- (i) surgical dressings, splints, casts, and other devices used to correct fractures and dislocations;
- (j) shots and injections when received in the Doctor's office;
- (k) acupuncture up to the maximum shown in the Plan of Insurance.

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If an Insured Person requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When the Insured Person requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Covered Charges incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility, including Hospitals.

What We pay is shown in the Plan of Insurance.

BENEFITS FOR OUTPATIENT SERVICES

We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance for covered outpatient services for the treatment of Mental and Nervous Conditions;

The Mental and Nervous Condition must, in the professional judgment of health care providers, be treatable, and the treatment must be Medically Necessary.

Outpatient Treatment and Doctor services include charges made by an outpatient treatment department of a Hospital or community mental health facility or charges for services rendered in a Doctor's office. Treatment may be provided by any properly licensed Doctor, psychologist or other provider as required by law.

What We pay is shown in the Plan of Insurance.

Definition

“Mental or Nervous Conditions”

This term means those conditions listed in the standard nomenclature of the American Psychiatric Association.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Principal Sum referred to in this provision is shown in the Plan of Insurance.

When, because of an Injury, the Insured Person suffers any of the following Losses within 365 days from the date of the Accident, We will pay as follows:

For Loss Of:

Life.....	Principal Sum
Two hands	Principal Sum
Two feet.....	Principal Sum
Sight of two eyes.....	Principal Sum
One hand and one foot.....	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye.....	Principal Sum
One hand or one foot or one eye	One-half Principal Sum
Thumb and Index Finger of Either Hand.....	One Quarter of Principal Sum

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

This provision does not cover the Loss if it in any way results from or is caused or contributed:

- (1) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;
- (2) By an infection, unless it is caused solely and independently by a covered Accident;
- (3) For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause.

In addition to the above, this provision is subject to the Exclusions as provided.

AMBULANCE EXPENSE BENEFIT

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area.

What We pay is shown in the Plan of Insurance.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such Durable Medical Equipment, subject to the Deductible shown in the Plan of Insurance. We pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is our property and is to be returned to Us, at Our expense, upon completion of the Insured Person's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

What We pay is shown in the Plan of Insurance.

Definition

"Durable Medical Equipment" means medical equipment that: 1) is prescribed by the Doctor who documents the necessity for the item including the expected duration of its use; 2) can withstand long term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision.

PRE-ADMISSION TESTS EXPENSE BENEFIT

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Charges made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Insured Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Plan of Insurance for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provides for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Insured Person only to the extent that the Insured Person is insured under this Policy for Hospital Expense Benefits.

What We pay is shown in the Plan of Insurance.

PRESCRIPTION DRUG EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires drugs, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such drugs and the Medically Necessary services associated with the administration of such drugs, subject to the Co-payment shown in the Plan of Insurance.

The drugs must be prescribed by a Doctor. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

- (1) the American Medical Association Drug Evaluations;
- (2) the American Hospital Formulary Service Drug Information;
- (3) the United States Pharmacopoeia Drug Information; or
- (4) it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

However, Covered Charges do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

What We pay is shown in the Plan of Insurance.

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to Insured Persons while Traveling Abroad and their Dependents. This benefit will pay benefits for the Covered Percentage of the Covered Expenses incurred, if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person.

What We pay is shown in the Plan of Insurance.

Definitions

“Emergency Medical Evacuation” means:

- (a) the Insured Person’s medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital or home residence where appropriate medical treatment can be obtained; or
- (b) for Domestic Students while Studying Abroad and their Dependents after being treated at a local Hospital; the Insured Person’s medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover.

“Covered Expenses” are Expenses up to the maximum stated in the Plan of Insurance for: (a) Transportation, (b) medical services, and (c) medical supplies necessarily incurred in connection with Emergency Medical Evacuation of the Insured Person. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company.

“Home Country” means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

“Transportation” means any land, water or air conveyance required to transport the Insured Person during an Emergency Medical Evacuation. Expenses for special transportation must be: (a) recommended by the attending Doctor; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Doctor.

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

This benefit applies only to Insured Persons while Traveling Abroad and their Dependents. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person’s remains to his or her Home Country or home residence. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit.

What We pay is shown in the Plan of Insurance.

Definitions

“Covered Expenses” include, but are not limited to, Expenses for embalming, cremation, coffins, and transportation.

“Home Country” means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

DIABETES EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary diabetes treatment and diabetes self-management training for a qualified Insured Person, including Medically Necessary supplies and equipment as ordered in writing by a Doctor or a licensed podiatrist.

A qualified Insured Person is one with:

- (a) insulin-using diabetes;
- (b) non-insulin using diabetes; or
- (c) elevated blood glucose levels induced by pregnancy or another medical condition;

Diabetes self-management training must be:

- (a) Medically Necessary;
- (b) ordered in writing by a Doctor or a licensed podiatrist; and
- (c) provided by a health care professional who:
 - (1) is licensed, registered, or certified under Indiana law; and
 - (2) has specialized training in the management of diabetes.

Coverage for diabetes self-management training is limited to the following:

- (a) one or more visits after receiving a diagnosis of diabetes;
- (b) one or more visits after receiving a diagnosis by a Doctor or a podiatrist that:
 - (1) represents a significant change in the qualified Insured Person's symptoms or condition; and
 - (2) makes change in the qualified Insured Person's self-management Medically Necessary.
- (c) one or more visits for reeducation or refresher training.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT

If an Insured Person who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, Covered Charges include those incurred for:

- (a) reconstruction of the breast on which the mastectomy was performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and treatment for physical complications from all stages of the mastectomy, including lymphedemas in a manner determined by the attending Doctor and the Insured Person.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

PERVASIVE DEVELOPMENTAL DISORDERS EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the treatment of a Pervasive Developmental Disorder prescribed by the Insured Person's treating Doctor in accordance with a treatment plan.

Any benefit, exclusion or limitation provisions in conflict with this benefit are not applicable to this benefit.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition

"Pervasive Developmental Disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

SECTION XII – EXCLUSIONS

The Policy does not cover nor provide benefits for:

1. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Speech therapy treatment;
3. Organ transplants, except as specifically provided;
4. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
5. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;
6. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
7. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
8. Correction of congenital defects except as specifically provided;
9. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth. This exclusion does not apply to any benefits specifically provided in an attached Amendatory Rider;
10. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain;
11. Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with Experimental or Investigational Care for the terminally ill;
12. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
13. Injury due to participation in a riot;
14. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
15. For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;
16. For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
17. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
18. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or Lasix or other vision

procedures except as required for repair caused by a covered Injury. This exclusion does not apply to any benefits specifically provided in an attached Amendatory Rider;

19. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;
20. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
21. An amount of a charge in excess of the Reasonable and Customary Expense;
22. Elective Treatment or elective surgery, except as specifically provided;
23. Services not Medically Necessary;
24. Oral contraceptives and other forms of contraception used for contraceptive purposes only;
25. Expenses for emergency room treatment for an Injury or Sickness not a Medical Emergency as defined in this Policy, including emergency "follow-up" visits;
26. Treatment of mental or nervous disorders except as specifically provided;
27. Treatment of alcohol and substance abuse except as specifically provided;
28. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; and learning disabilities or disorders or Attention Deficit Disorder;
29. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;
30. Care, treatment or supplies furnished by a program or agency funded by any government;

SECTION XIII - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. The entire contract is made up of: (a) this Policy, including Your Application; and (b) the individual applications, if any, of Insured Persons. Statements made by the Policyholder or an Insured Person shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance, unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person, or to his/her beneficiary. No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidenced by endorsement on this Policy, or by amendment of this Policy signed by the Policyholder and Us. No agent has authority to change this Policy or to waive any of its provisions.

GRACE PERIOD. A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. You shall be liable to Us for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to Us within 20 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 Us at Our Administrative Office or to any authorized agent, with information sufficient to identify the Insured Person, shall be deemed notice to Us.

CLAIM FORMS. Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of Loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of Loss by giving written proof of: (a) the occurrence of the Loss; (b) the nature of the Loss; and (c) the extent of the Loss.

PROOF OF LOSS. Written proof of Loss must be given to Us at Our Home Office 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.

TIME 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 Us.

PAYMENT OF CLAIMS. All benefits for Loss other than death will be paid to the Insured Student. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. It is not required that the service be rendered by a particular Hospital or person. The Insured Person must make a written request to Us before We can do this. We must receive the request no later than the time for filing proof of Loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured Student. This choice must be in writing and filed with Us. If the Insured Student has not chosen a beneficiary, or if there is no beneficiary alive when the student dies, We will pay:

- (a) his/her parents or legal guardian, if a minor;
- (b) otherwise, We will pay his/her estate.

We will pay these benefits immediately upon receipt of due written proof of such Loss.

PHYSICAL EXAMINATION. At Our own expense, We have the right to have a Doctor examine an Insured Person when and so often as We deem reasonably necessary while there is a claim pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

LEGAL ACTIONS. No one may sue Us 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. You shall maintain records of each person insured. The records shall show all data that is needed to administer this Policy.

EXAMINATION AND AUDIT. We shall be allowed to examine and audit Your books and records which pertain to this Policy at reasonable times. We may 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.

CERTIFICATES OF INSURANCE. Where required by law, a certificate of insurance will be delivered to the Policyholder for delivery to each Insured Student. The certificate will list the benefits, conditions and limits of the Policy and will state to whom benefits will be paid.

CONFORMITY WITH STATE STATUTES. Any provision of this Policy which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

SECTION XIV - COORDINATION OF BENEFITS

This section will be used to determine an Insured Person's benefits under this Policy IF:

the Insured Person is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans,

and

the 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. group, blanket or franchise insurance coverage; this does not apply to blanket school accident only coverages;
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;
5. any group or group type hospital indemnity of more than \$200.00 per day;
6. Medicare (Title XVIII of the Social Security Act); and
7. any part of a state auto reparation or indemnity act (no fault insurance) with which the state permits coordination.

Plan does not include individual or family policies; individual or family subscriber contracts except as stated. Nor does it include any group or group type hospital indemnity of \$200.00 or less per day; or medical payment benefits customarily included in the traditional automobile contracts.

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; and
- at least partly covered under one of the plans covering such Insured Person.

When this plan 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.

EFFECT 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 calendar 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 calendar 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:

1. The plan which covers the Insured Person as an employee rather than as a full or part-time student.

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.

2. If 1 does not apply, the plan which covers the person as a full or part-time student rather than as a dependent.
3. If 1 and 2 do not apply, the plan which covers the person as a dependent of the parent whose month and date 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.

A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.

4. If 1, 2, or 3 do not apply, the plan which has covered the insured person for the longer time rather than the shorter time.

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, We must exchange information with other plans. To do so, We may give to, or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Us the required information.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. This will be done at Our discretion. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.

SECTION XV – INTERNAL AND EXTERNAL GRIEVANCE PROCEDURES

INTERNAL GRIEVANCE PROCEDURES

A "grievance" is any dissatisfaction expressed by or on behalf of an Insured Person regarding:

- (1) a determination that a service or proposed service is not appropriate or Medically Necessary;
- (2) a determination that a service or proposed service is Experimental or Investigational Care;
- (3) the availability of Network Providers;
- (4) the handling or payment of claims for health care services; or
- (5) matters pertaining to the contractual relationship between an Insured Person and Us or between the Policyholder and Us;

and for which the Insured Person has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

An Insured Person may file a grievance orally or in writing. We shall make available to Insured Persons a toll free telephone number through which a grievance may be filed. The toll free telephone number shall:

- (1) be staffed by a qualified representative of Ours;
- (2) be available for at least forty (40) hours per week during normal business hours; and
- (3) accept grievances in the languages of the major population groups served by Us.

A grievance is considered to be filed on the first date it is received, either by telephone or in writing. An Insured Person may designate a representative to file a grievance for the Insured Person and to represent the Insured Person in a grievance.

We shall:

- (1) Acknowledge the grievance, given orally or in writing, to the Insured Person within five (5) business days after receipt of the grievance.
- (2) Document the substance of the grievance and any actions taken.
- (3) Investigate the substance of the grievance, including any aspects involving clinical care.
- (4) Notify the Insured Person of the disposition of the grievance and the right to appeal in a manner that accommodates the clinical urgency of the situation.
- (5) appoint at least one individual to resolve a grievance.

A grievance shall be resolved as expeditiously as possible, but not more than twenty (20) business days after We receive all information reasonably necessary to complete the review. If We are unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond Our control, We shall:

- (1) before the twentieth business day, notify the Insured Person in writing of the reason for the delay; and
- (2) issue a written decision regarding the grievance within an additional ten (10) business days.

We shall notify an Insured Person in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice shall include the following:

- (1) A statement of Our decision.
- (2) A statement of the reasons, policies, and procedures that are the basis of the decision.
- (3) Notice of the Insured Person's right to appeal the decision.
- (4) The department, address, and telephone number through which an Insured Person may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Appeals of Grievance Decisions

An Insured Person may file an appeal of a grievance decision orally or in writing. We shall:

- (1) Acknowledge the appeal, given orally or in writing, to the Insured Person within five (5) business days after the appeal is filed.
- (2) Document the substance of the appeal and the actions taken.
- (3) Investigate the substance of the appeal, including any aspects of clinical care involved.
- (4) Notify the Insured Person of the disposition of the appeal and that the Insured Person may have the right to further remedies allowed by law in a manner that accommodates the clinical urgency of the situation.

In the case of an appeal of a grievance decision regarding:

- (1) a determination that a service or proposed service is not appropriate or Medically Necessary; or
- (2) a determination that a service or proposed service is Experimental or Investigational Care;

We shall appoint a panel of one or more qualified individuals to resolve an appeal. The panel shall include one or more individuals who:

- (1) have knowledge of the medical condition, procedure, or treatment at issue;
- (2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- (3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and
- (4) do not have a direct business relationship with the Insured Person or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

An appeal of a grievance decision shall be resolved:

- (1) as expeditiously as possible, reflecting the clinical urgency of the situation; and
- (2) not later than forty-five (45) days after the appeal is filed.

We shall allow an Insured Person the opportunity to appear in person before, or if unable to appear in person, otherwise appropriately communicate with the panel.

We shall notify an Insured Person in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing an investigation. The grievance resolution notice shall include the following:

- (1) A statement of Our decision.
- (2) A statement of the reasons, policies, and procedures that are the basis of the decision.
- (3) Notice of the Insured Person's right to further remedies allowed by law, including the right to external grievance review by an independent review organization as described below.
- (4) The department, address, and telephone number through which an Insured Person may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

EXTERNAL REVIEW OF GRIEVANCES

The external grievance procedure is available for the resolution of external grievances regarding:

- (1) an adverse determination of appropriateness;
 - (2) an adverse determination of Medical Necessity; or
 - (3) a determination that a proposed service is Experimental or Investigational Care;
- made by Us or Our agent regarding a service proposed by the treating health care provider.

An Insured Person or an Insured Person's representative may file a written request with Us for an external grievance review of Our appeal resolution not more than forty-five (45) days after the Insured Person is notified of the resolution.

We shall provide:

- (1) An expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the Insured Person's life, health or ability to reach and maintain maximum function; or
- (2) a standard external grievance review for a grievance not described in (1) above.

An Insured Person may not file more than one external grievance of Our appeal resolution.

When a request is filed, We shall:

- (1) select a different independent review organization for each external grievance filed from the list of independent review organizations that are certified by the department; and
- (2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

The independent review organization chosen shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance. The independent review organization and the medical review professional conducting the external review may not have a professional, familial, financial, or other affiliation with any of the following:

- (1) Us;
- (2) Any officer, director, or management employee of Ours;
- (3) The health care provider or the health care provider's medical group that is proposing the service;
- (4) The facility at which the service would be provided;
- (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider;
- (6) The Insured Person requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of Ours and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the Insured Person and Us before commencing the review and neither the Insured Person nor We object.

An Insured Person will be required to pay twenty-five (\$25) of the costs associated with the services of an independent review organization. All additional costs will be paid by Us.

An Insured Person who files an external grievance:

- (1) shall not be subject to retaliation for exercising the Insured Person's right to an external grievance;
- (2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
- (3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and
- (4) shall cooperate with the independent review organization by providing any requested medical information or authorizing the release of necessary medical information.

We shall cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

An independent review organization shall:

- (1) for an expedited external grievance, within three (3) business days after the external grievance is filed; or
 - (2) for a standard appeal, within fifteen (15) business days after the appeal is filed;
- make a determination to uphold or reverse Our appeal resolution based on information gathered from the Insured Person or the Insured Person's designee, Us, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

When making the determination, the independent review organization shall apply standards of decision making that are based on objective clinical evidence and the terms of the Policy.

The independent review organization shall notify Us and the Insured Person of the determination made:

- (1) for an expedited external grievance, within twenty-four (24) hours after making the determination; and
- (2) for a standard external grievance, within seventy-two (72) hours after making the determination.

The independent review organization's determination is binding on Us.

If, at any time during an external review, the Insured Person submits information to Us that is relevant to Our resolution of the Insured Person's appeal of a grievance decision and that was not previously considered by Us:

- (1) We may reconsider the resolution; and
- (2) if We choose to reconsider, the independent review organization shall cease the external review process until such reconsideration is completed.

We shall reconsider the resolution based on the information and notify the Insured Person of Our decision:

- (1) within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the Insured Person's life, health or ability to reach and maintain maximum function; or
- (2) within fifteen (15) days after the information is submitted, for a reconsideration not described in (1) above.

If the decision reached is adverse to the Insured Person, the Insured Person may request that the independent review organization resume the external review.

If We choose not to reconsider Our resolution, We shall forward the submitted information to the independent review organization not more than two (2) business days after Our receipt of the information.

SECTION XVI - SUBROGATION AND RECOVERY RIGHTS

RIGHT TO SUBROGATION: If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Insured Person will do what ever is necessary to enable Us to exercise Our right and will do nothing after Loss to prejudice it. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

RIGHT TO REIMBURSEMENT: If benefits are paid under this Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Insured Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

LIMITATION TO OUR RECOVERY RIGHTS: We may exercise Our Right to Subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under the Policy. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a responsible third party.

SECTION XVII - EXTENSION OF BENEFITS

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 60 day period following such termination of insurance.