



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-3102
(803) 735-1251
(the "Company")

POLICYHOLDER: North Park University
POLICY NO.: CLSP0025-11
EFFECTIVE DATE: August 15, 2011
POLICY TERM: August 15, 2011 to September 1, 2012
PREMIUM DUE DATE: On or before the Policy Effective Date

READ YOUR POLICY CAREFULLY: This Policy is a legally binding contract between the Insured and Companion Life Insurance Company ("Company" or "Insurer"). The consideration for this Policy includes, but is not limited to, the Application and the payment of premiums as provided for herein. It is governed by the laws of the state in which it is issued.

The Company will pay the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy.

The Insured agrees to pay premiums when due and to comply with the Policy provisions.

The sections set forth on the following pages are a part of this Policy and take effect on the Effective Date. All periods indicated in the Policy begin and end at 12:00 a.m. Standard Time at the Insured's principal place of business.

IN WITNESS WHEREOF the Companion Life Insurance Company has caused this Policy to be executed by its President at Columbia, South Carolina.

A handwritten signature in black ink, appearing to read 'Trescott N. Hinton, Jr.'.

Trescott N. Hinton, Jr.
President

**BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE POLICY
PLEASE READ THIS POLICY CAREFULLY**

IMPORTANT NOTICE

Should any complaints arise regarding this insurance, you may contact the plan sponsor or any of the following offices:

The insurer who issued the group policy may be contacted by addressing:

Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, SC 29223-5666

or by calling the toll free number shown on your ID card.

The group policy is subject to the laws of Illinois. The state may be contacted by addressing:

State of Illinois
Division of Insurance
320 W. Washington
Springfield, Illinois 62767-0001

EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.

Providers may bill for any amount up to the billed charge after the plan has paid its portion of the bill. Further information about the out-of-pocket expenses may be obtained by calling the toll free telephone number on the identification card.

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SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS:

- I. All students are eligible to participate in this Plan. Students who do not complete a waiver providing their health insurance information will be automatically enrolled in this insurance plan and the fees will be added to their bill.
- II. Dependents of Insured Students, as defined in the Definitions Section of this Policy.

Students must actively attend classes for at least the first 31 days from their effective date of coverage, or the entire period for which coverage is purchased, whichever is the lesser, except in the case of medical withdrawal (as verified and approved by the school).

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

Unless otherwise specified, any Deductibles, Co-payments, Co-insurance Percentages and Benefit Maximums apply on a per Covered Person, per Covered Accident/covered Sickness and Coverage Period basis.

Scope of Coverage:

Benefits will be paid up to the Benefit Maximums shown for each service shown in the schedule below.

Part A Basic Injury Benefit – Per Accident

Per Covered Person: \$2,000

Part B Basic Sickness Benefit – Per Sickness

Per Covered Person: \$2,000

Part C Major Medical Benefit – Per Condition (Accident or Sickness)

Per Covered Person: \$100,000

Deductible:

Per Covered Person per policy year: \$100 in-network
\$100 out-of-network

After the Company has paid \$2,000 under Part A or Part B and the Insured has paid a \$2,000 Major Medical Deductible, the Company will then pay 80% for In-Network and 60% for Out-of-Network treatment, up to a Maximum Benefit for each Injury or Sickness of \$100,000. This maximum includes benefits paid under both the Basic Benefits and Optional Major Medical Benefits. Benefits shall end at the close of the period of coverage under this policy.

HEALTH SERVICES STUDENT INSURANCE LIST (Continued)		
Part A – Basic Injury Benefit	In-Network	Out-of-Network
Medical and Surgical Treatment by a physician	100% of Preferred Allowance	80% of Usual and Customary
Hospital Confinement and Miscellaneous hospital expenses	100% of PA	80% of U&C
Dental Treatment Including x-rays – for repair and/or replacement of sound and natural teeth (does not include biting or chewing injuries)	100% of PA \$200 maximum	80% of U&C \$200 maximum
Physical Therapy	100% of PA	80% of U&C
Outpatient Prescription Drugs	100% of PA	80% of U&C
Motor Vehicle Injury	100% of PA	80% of U&C
All Other Covered Services	100% of PA	80% of U&C
Injury as a result of play or practice of intercollegiate athletics	100% of PA \$500 maximum	80% of U&C \$500 maximum

Part B – Basic Sickness Benefit	In-Network	Out-of-Network
Hospital Room and Board	100% of Preferred Allowance	80% of Usual and Customary
Hospital Miscellaneous Inpatient For x-ray examinations, laboratory tests, anesthesia, operating room, medications, dressings, etc.	100% of PA	80% of U&C
Hospital Outpatient Surgical Miscellaneous (in lieu of inpatient)	100% of PA	80% of U&C
Anesthetist	25% of Paid Surgical Expense	25% of Paid Surgical Expense
Physician's Non-Surgical Visits Inpatient – not paid day of surgery	100% of PA \$100 per visit, first 3 days \$50 per visit thereafter Limit one visit per day	80% of U&C \$100 per visit, first 3 days \$50 per visit thereafter Limit one visit per day
Physician's Non-Surgical Visits Outpatient – not paid day of surgery	100% of PA \$50 per visit Maximum 10 visits	80% of U&C \$50 per visit Maximum 10 visits
Outpatient Diagnostic, X-Ray and Lab Services	100% of PA	80% of U&C

Hospital Emergency Room (Outpatient)	100% of PA	80% of U&C
Mental & Nervous Disorders (Outpatient)	100% of PA When required, beginning with the second such visit, 50% of the charges will be payable to a maximum of \$50 per visit Maximum 10 visits Limit one visit per day	80% of U&C When required, beginning with the second such visit, 50% of the charges will be payable to a maximum of \$50 per visit Maximum 10 visits Limit one visit per day
Substance Abuse (Outpatient)	100% of PA \$50 per visit Maximum 10 visits Limit one visit per day	80% of U&C \$50 per visit Maximum 10 visits Limit one visit per day
Consultant's Fees When required by attending physician	100% of PA \$250 maximum	80% of U&C \$250 maximum
Maternity Benefits Conception must occur while coverage is in force	Paid the same as any other Sickness	
Outpatient Prescription Drugs	\$200 per Sickness	

COVERAGE PERIODS AND PREMIUM RATES

2011-2012 PREMIUM RATES

Coverage Available for	Annual 8/15/2011- 9/1/2012	Spring & Summer 1/13/2011- 9/1/2012	Summer Only 5/14/2011- 9/1/2012
Student Only	\$1,374	\$1,031	\$ 481
Spouse Add	\$3,734	\$2,801	\$1,307
All Children Add	\$2,712	\$2,034	\$ 950

DEFINITIONS

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

"Complications of Pregnancy" means conditions which require medical treatment before pregnancy ends, and whose diagnosis is distinct from, but are caused or affected by pregnancy. Such conditions are; acute nephritis or nephrosis, cardiac decompensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination when a live birth is not possible.

Complications of Pregnancy does not include: false labor; occasional spotting; voluntary abortion; Doctor prescribed rest during pregnancy; morning sickness; and similar conditions not medically distinct from a difficult pregnancy.

"Copayment" means the specified dollar amount an Insured Person must pay for specified charges. The copayment 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 Usual 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 Covered Person except with respect to any expense payable under the Extension of Benefits Provision.

"Covered Person" means any eligible person or an eligible Dependent who applies for coverage, and for whom the required premium is paid to Us.

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

DEFINITIONS (Continued)

"Dependent" means: 1) an Insured's lawful spouse; or 2) an Insured's unmarried child, from the moment of birth to age 19, 23 if a full-time student, who is chiefly dependent on the Insured for support.

A "child", includes an Insured's: 1) natural child; 2) stepchild; and 3) adopted child, beginning with any waiting period pending finalization of the child's adoption.

Coverage will continue for a child who is 19 or more years old, chiefly supported by his or her parent or dependent on other care providers and incapable of self-sustaining employment by reason of a handicapped condition that occurred before the attainment of the limiting age. Proof of the child's condition and dependence will be requested by Us within 2 months prior to the date the child will cease to qualify as a child as defined above. Such proof must be submitted to Us within 31 days from the date of the request. We may, at reasonable intervals thereafter, require proof of the continuation of such condition and dependence. If proof is not submitted within the 31 days following any such request, coverage for the Dependent will terminate.

With respect to a handicapped child, "dependent on other care providers" means such child requires a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services, the Department of Public Health, or the Department of Public Aid.

The term "spouse" also includes your domestic partner. You and your domestic partner must submit a complete domestic partner affidavit and meet the following criteria to qualify your domestic partner for insurance under this group policy. For at least six consecutive months prior to the effective date of your domestic partner insurance, you and your domestic partner:

1. are and have been each other's sole domestic partner, and have maintained the same principal place of residence and intend to do so indefinitely;
2. are both at least 18 years of age;
3. are not married or related by blood; and
4. are jointly responsible for each other's welfare and financial obligations.

The term also includes the child of your domestic partner. Any such child must be unmarried and under age 19, 23 if a full-time student.

"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; (c) a certified nurse midwife while acting within the scope of that certification.

DEFINITIONS (Continued)

"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; 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 examination.

"Experimental or Investigational": means any procedure, treatment, facility, supply, device, or drug that:

1. is not generally accepted by the United States medical community as effective for diagnosis, care or treatment; or
2. is subject to research protocols indicating that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational;" or
3. requires the patient to sign a consent form which indicates that the procedure, treatment, supply, device, or drug is "experimental or investigational" or is part of a research or study program; or
4. requires the provider's institutional review board to acknowledge that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational," and subject to the board's approval.

Important Notice - The insurer may rely upon the advice of medical and dental peer review groups and other medical and dental experts to determine which services and/or supplies are experimental or investigational. The decision whether there is enough scientific data, and the decision whether a service or supply is "experimental or investigational" will be made by the insurer.

The insurer will determine, in its discretion, whether a procedure, treatment, facility, supply, device, or drug is "experimental or investigational"

"Home Health Care" means nursing care and treatment and Daily Living Services provided to a Covered Person in His home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1. the Home Health Care plan must be established and approved in writing by a Covered Person's attending Doctor, including certification in writing by the attending Doctor that confinement in a Hospital or extended care facility would be required in the absence of Home Health Care;
2. nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency; and
3. Daily Living Services must be approved in writing by the attending Doctor or by the provider of the nursing care services.

"Daily Living Services" means cooking, feeding, bathing, dressing and personal hygiene services performed by a Home Health Aide, and which are necessary to the care and health of the Covered Person.

DEFINITIONS (Continued)

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

- (a) It provides inpatient services for the care and treatment of injured and sick people;
- (b) It provides room and board services and nursing services 24 hours a day;
- (c) It has established facilities for diagnosis and major surgery;
- (d) It is supervised by a Doctor
- (e) It is run as a Hospital under the laws of the jurisdiction in which it is located.

Hospital also means a licensed alcohol and drug abuse rehabilitation facility or a mental hospital. Alcohol and drug abuse rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

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

"Immediate Family" means a Covered Person's parent, spouse, child, brother or sister.

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

"Insured Person" means and Insured Student and their covered Dependent(s) while insured under this Plan.

"Insured Student" means a student of St. Xavier University who is eligible and insured for coverage under this Plan.

"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.

DEFINITIONS (Continued)

"Medically Necessary" means a service, drug or supply which is necessary and appropriate for the diagnosis and treatment of a Covered Injury and Covered Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply will not be considered as Medically Necessary if, it:

1. is investigational, experimental or for research purposes;
2. is provided solely for the convenience of the patient, the patient's family Doctor, Hospital or any other provider;
3. exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. could have been omitted without adversely affecting the person's condition or the quality of medical care; or
5. involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration.

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

"Prescription Drugs" mean 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a Doctor; and 4) injectable insulin.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Usual and Customary Charge" means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

"We, Our, Us" means Companion Life Insurance Company, Inc., or its authorized agent.

ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured under the Policy. This includes anyone who may become eligible on the Policy Effective Date, and after the Policy Effective Date while the Policy is in force. Students must actively attend class for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, on-line, and television (TV) courses do not fulfill the eligibility requirements. We maintain the right to investigate student status and attendance records to verify eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any premium paid for that person.

A person may be insured under only one class of Eligible Persons shown in the Schedule of Benefits, even though the person may be eligible under more than one Class.

An Insured's Dependent is eligible on the date:

1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent of the Insured, if later.

In no event will a Dependent be eligible if the Insured is not enrolled.

EFFECTIVE DATE OF INSURANCE

Insurance for an Eligible Person who enrolls during the enrollment period established by the school is effective on the latest of the following dates:

1. the Policy Effective Date;
2. the date We receive the completed enrollment form;
3. the date the required premium is paid; and
4. the date the student enters the Eligible Class.

Coverage for a student's eligible Dependent who enrolls:

1. during the enrollment period established by the Policyholder; or
2. within 31 days after the student acquires a new Dependent; or
3. within 31 days after a Dependent terminates coverage under another Health Care Plan,

is effective on the latest of the following dates:

1. the first day of the Coverage Period;
2. the date the student enters the Eligible Class;
3. the date We receive the completed enrollment form; and
4. the date the required premium is paid.

After the time periods described above, the student must wait until the next enrollment period, except for a newborn or a newly adopted child and involuntary loss of coverage under another Health Care Plan.

We will pay benefits for a newborn child of the Insured until that child is 31 days old. Coverage may be continued beyond 31 days if the Insured notifies US of the child's birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date of the child is placed for adoption with the Insured. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates. An adopted child is one who has not yet attained 18 years of age.

ELIGIBILITY FOR INSURANCE

EFFECTIVE DATE OF INSURANCE (Continued)

"Placed for adoption" means circumstances under which the Insured assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement ends at the time such legal obligation ends.

Coverage for newborn and adopted children will consist of coverage for covered Injury or covered Sickness including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well born care, birth abnormalities, and routine nursery care related with a covered Sickness.

TERMINATION

TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earliest of the date:

1. the Policy terminates;
2. the Insured is no longer eligible; or
3. the period ends for which premium is paid.

A Dependent's coverage will end on the earliest of the date:

1. he or she is no longer a Dependent;
2. the Insured's coverage ends; or
3. the period ends for which premium is paid; or
4. the Policy terminates.

REFUND OF PREMIUM

In the event the insured student withdraws from school or reduces his/her semester hours to less than 6, within the first 30 days of the semester. We will refund any premiums paid for the student and any covered Dependents.

A pro-rata refund of premium will be made only in the event:

1. the Covered Person enters full-time active duty in any Armed Forces; and
2. We receive proof of such active duty service.

EXTENSION OF BENEFITS

If a Covered Person is confined in a Hospital for a medical condition on the date his insurance ends, expenses Incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the 90 day period following the termination of insurance. We will not continue to pay these Covered Expenses if:

1. the Covered Person's medical condition no longer continues;
2. the Covered Person reaches the Lifetime Aggregate Maximum per covered Accident or covered Sickness; or
3. the Covered Person obtains other coverage.
4. the Covered Expenses are incurred more than 3 months following termination of insurance

CONTINUATION OF COVERAGE

A Covered Person who has been insured under the Policy may continue to be insured under the Policy when coverage terminates subject to the following:

1. Continuation of Coverage is available to Insureds, and their covered Dependents, when the Insured leaves school, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.
2. The Covered Person requesting coverage must have been insured under the Policy for at least 6 months.

TERMINATION (Continued)

CONTINUATION OF COVERAGE (Continued)

3. Requests for Continuation of Coverage, with the applicable premium, must be mailed to the Plan Administrator, before the termination of existing coverage and while the Covered Person still meets the eligibility criteria.
4. Coverage and benefits will be the same as those, which are applicable prior to continuation.
5. Premium rates for Continuation of Coverage are higher than student rates. Rates, and forms to request Continuation of Coverage, are available in the Student Insurance Office.
6. The maximum period for which coverage may be continued is 12 months.
7. Continuation of Coverage is not available to persons who are eligible for coverage under another Health Care Plan, including Medicare.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

We will pay the Covered Expenses as shown in the Schedule of Benefits if a Covered Person requires treatment by a Doctor. We will consider the Usual and Customary Charges incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the deductibles, co-insurance factors and benefit maximums, if any, shown in the Schedule of Benefits.

Covered Expenses include:

Inpatient Expenses

1. Hospital Room and Board Expenses: daily semi-private room rate when Hospital Confined as shown in the Schedule of Benefits; and general nursing care provided and charged for by the Hospital.
2. Intensive Care: we will make this payment in lieu of the semi-private room expenses.
3. Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
4. Surgery: Doctor's fees for inpatient surgery. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.
5. Anesthetist Services: in connection with inpatient surgery.
6. Doctor's Visits: when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.
7. Organ Transplant: including non-investigative and non-experimental human organs and tissue transplants that are Medically Necessary.

Outpatient Expenses

9. Day Surgery (Outpatient): Surgeon's and Assistant Surgeon's fees for outpatient surgery. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.
10. Day Surgery Miscellaneous Expenses: Includes services related to scheduled surgery performed in a Hospital, ambulatory surgical center, operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. Benefits will not be paid for: surgery performed in a Hospital emergency room, Doctor's office, or clinic.
11. Anesthetist Services: in connection with outpatient surgery.

DESCRIPTION OF BENEFITS (Continued)

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS (Continued)

12. Doctor's Visits: Includes well visits and routine GYN exams; benefits are limited to one visit per day. Benefits will not be paid when related to surgery.
13. Physical Therapy and Chiropractic Expenses: benefits are limited to one visit per day.
14. Diagnostic X-ray Services: Includes diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray and lab procedures.
15. Medical Emergency Expenses: only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 48 hours from time of Injury or first onset of Sickness.
16. Radiation & Chemotherapy: as shown in the Schedule of Benefits.
17. Laboratory Procedures: as shown in the Schedule of Benefits.

Other Expenses

18. Ambulance Service. Payment will be made to the provider as shown in the Schedule of Benefits.
19. Braces and Appliances: 1) when prescribed by a Doctor; and 2) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment which is equipment that:
 - a. is primarily and customarily used to serve a medical purpose;
 - b. can withstand repeated use; and
 - c. generally is not useful to person in the absence of Injury.No benefits will be paid for rental charges in excess of the purchase price.
20. Consultant Doctor Fees: when requested and approved by the attending Doctor. Covered Expenses will be paid under this benefit or under the Doctor's Visits benefit, but not for the same day.
21. Dental Treatment (Injury Only): when performed by a Doctor and made necessary by Injury to sound, natural teeth. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.
22. The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, to the extent shown in the Schedule of Benefits, Certain maternity testing may not be covered under the Policy. The following maternity routine tests and screening exams may be payable if all of the terms and conditions of the Policy are met: a pregnancy test, CBC, Hepatitis B, Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24 - 28 weeks gestation), one ultrasound (subsequent ultrasounds only if they are ordered by a Doctor as Medically Necessary and if a claim is submitted with the pregnancy record and ultrasound report confirming the Medical Necessity), and for a Covered Person over age 35, AFP Blood Screening, Amniocentesis/AFP Screening, Chromosome Testing, Fetal Stress/Non-Stress tests. Pre-natal vitamins are not covered.
Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
 - a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
 - b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

DESCRIPTION OF BENEFITS (Continued)

Other Expenses (Continued)

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the Doctor in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health, and shall include:

- a. Parental education;
- b. Assistance and training in breast or bottle feeding; and
- c. Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.]

23. Routine Well-Baby Care: 1) while the baby is Hospital Confined; and 2) for routine nursery care provided immediately after birth, including treatment of diagnosed congenital and birth abnormalities.

24. Well Child Care: including immunizations and age-appropriate screening tests.

25. Durable Medical Equipment. Prosthetic Appliances and Medical Services: for Medically Necessary services.

ADDITIONAL BENEFITS

Emergency Services Prior to Stabilization

Coverage for emergency services as provided under this Policy is provided without regard to prior authorization.

The medical director's or his or her designee's determination of whether the condition Covered Person meets the standards of an emergency medical condition shall be based solely upon the presenting symptoms documented in the medical record at the time care was sought. Only a clinical peer may make an adverse determination.

The appropriate use of the 911 emergency telephone system or its local equivalent shall not be discouraged or penalized by the health care plan when an emergency medical condition exists.

Note: This provision shall not imply that the use of 911 or its local equivalent is a factor in determining the existence of an emergency medical condition.

Mammography Examinations and Pap Smear Test Expense Benefit

Benefits payable under the group policy include covered expenses incurred by a Covered Person for mammography examinations for the presence of occult breast cancer.

Benefits payable for routine mammography screenings, however, will be limited to the following schedule:

1. one baseline mammography examination for women age 35 through age 39;
2. an annual mammography examination for women age 40 and older.

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

Benefits are also payable under the group policy for expenses incurred by a covered person for annual cervical or Pap Smear test.

The benefits payable for mammography screening and Pap Smears are payable to the same extent as any other screening or test, and are subject to all of the provisions and limitations of the Policy.

Bone Mass Measurement and Osteoporosis Treatment Expense Benefit

We will pay covered Expenses incurred by a Covered Person for bone mass measurement, and the diagnosis and treatment of osteoporosis.

Benefits are payable to the same extent as for any other covered sickness and subject to all of the provisions and limitations of the Policy.

Mental and Nervous Conditions Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for Medically Necessary treatment of Mental and Nervous Conditions furnished, as described below.

Benefit payments for Mental and Nervous Conditions will be subject to any Deductible, Coinsurance rate, Benefit Maximum, lifetime Aggregate Benefit Maximum, and Benefit Period shown in the Schedule of Benefits.

The Covered Person may select any Doctor, clinical psychologist or clinical social worker, who is licensed by the state in which services are rendered, to treat such ailments. The Insurer will pay the Covered Expenses for such treatment up to the limits stated in the Schedule of Benefits, provided that: (a) the ailment treated is covered by this Policy; and (b) the Doctor, psychologist or social worker is acting within the scope of his or her license in rendering such treatment.

Serious Mental Illness Expense Benefit

Benefits payable under the group policy include covered expenses incurred by a covered person for Medically Necessary care and treatment of a serious mental illness.

For the purposes of this provision, the term "serious mental illness" means those psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, including:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (hypomanic, manic, depressive, and mixed);

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

4. Major depressive disorders (single episode or recurrent);
5. Schizoaffective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive-compulsive disorders;
8. Depression in childhood and adolescence;
9. Panic disorder;
10. Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
11. Anorexia nervosa and bulimia nervosa.

Coverage for the care and treatment of serious mental illness are subject to all of the provisions that would apply to any other hospital or medical expense covered under the policy.

Benefits will be payable as shown in the Schedule of Benefits. An outpatient visit for the purpose of medication management will not be counted toward the outpatient limit shown in the Schedule of Benefits.

This provision does not provide coverage for treatment of:

1. Addiction to a controlled substance or cannabis that is used in violation of the law; or
2. Mental illness resulting from the use of a controlled substance or cannabis in violation of the law.

Alcoholism and Drug Abuse Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for:

1. Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Inpatient hospital services have a minimum standard of 120 days of non-mental health inpatient services per year, including all professional services, medications, surgically implanted devices and supplies used by the enrollee while an inpatient;
2. Rehabilitation services on an inpatient basis, for up to 10 days inpatient care per year. Care in a day hospital, residential non-hospital or intensive outpatient treatment mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by the primary care physician. Twenty individual outpatient care visits per enrollee per year as appropriate for evaluation, short-term treatment, and crisis intervention services. Group outpatient care visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by the primary care physician. Prolonged rehabilitation services in a specialized inpatient or residential facility need not be a part of Basic Health Care Services.

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

Inpatient Care Following Mastectomy

Inpatient benefits following a mastectomy will be provided for a length of time determined by the attending Doctor to be Medically Necessary. The length of time will be based on the evaluation of the patient and the availability of post-discharge doctor's office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Benefits will be payable on the same basis as any other illness under the Policy.

"Mastectomy" means the surgical removal of all or part of a breast.

Breast Reconstructive Surgery after Mastectomy

The federal Women's Health and Cancer Rights Act requires coverage for certain treatment related to mastectomy. If you are eligible for mastectomy benefits under this Policy and you elect breast reconstruction in connection with such mastectomy, you also are covered for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications of all stages of mastectomy, including Lymphedemas.

Coverage for breast reconstructive surgery may not be denied or reduced on the grounds that it is cosmetic in nature or, that it otherwise does not meet the group policy definition of "Medically Necessary" or "medically required."

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

Benefits will be payable on the same basis as any other illness or injury under the Policy, including the application of appropriate deductibles and coinsurance amounts.

Hospitalization and Anesthesia Related to Dental Procedures

We will pay the Covered Expenses incurred for Hospital or Ambulatory Surgical Center services and for anesthetics in conjunction with dental procedures for a Covered Person who:

1. Is a dependent child age 6 or under; or
2. Has a medical condition that requires hospitalization or general anesthesia for dental care; or
3. Is disabled.

For purposes of this provision, "disabled" means a person, regardless of age, with a chronic disability that meets all of the following conditions:

1. It is attributable to a mental or physical impairment or combination of both;
2. It is likely to continue; or
3. It results in substantial functional limitations in 1 or more of the following areas of major life activity:
 - a. self-care;
 - b. receptive and expressive language;
 - c. learning;
 - d. mobility;
 - e. capacity for independent living; or
 - f. economic self-sufficiency.

Coverage will be subject to all conditions and limitations of the Policy. Benefits for these services will be payable to the same extent as when they are provided for any other covered Sickness or Injury.

Services for dental care are not covered except as may otherwise be provided by the Policy.

Prostate Cancer Screening Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for an annual Prostate Cancer Screening for covered men upon the recommendation of a Doctor, for prostate cancer screening tests as follows.

Benefits cover an annual digital rectal exam and a prostate-specific antigen ("PSA") blood test for:

1. asymptomatic men age 50 and over;
2. African-American men age 40 and over; and
3. men age 40 and over with a family history of prostate cancer.

These benefits are payable to the same extent as any other diagnostic exam; and are subject to all of the provisions and limitations of the Policy.

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

Colorectal Cancer Screening Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for colorectal cancer examinations and laboratory tests when ordered or authorized by a Doctor. Such examinations and testing must be consistent with the American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies.

These benefits are payable to the same extent as any other diagnostic exam, and are subject to all of the provisions and limitations of the Policy.

Diabetes Coverage

Benefits will be paid for Covered Expenses incurred by a Covered Person for Medically Necessary equipment and related supplies for the treatment of diabetes when prescribed by a Doctor or other licensed health care provider.

Benefits for such charges will be payable on the same basis as any other illness under the Policy.

Equipment and related supplies which may be Medically Necessary include, but are not limited to, the following:

1. Blood glucose monitors;
2. Blood glucose monitors for the visually impaired;
3. Diabetes data management systems for management of blood glucose;
4. Insulin pumps and equipment for the use of the pump including batteries;
5. Insulin infusion pumps; and
6. Podiatric appliances and therapeutic footwear.

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a licensed Doctor.

Benefits are payable on the same basis as any other covered Sickness under the Policy.

Diabetic Self-Management Education Programs

Benefits are payable for Covered Expenses incurred for a program of instruction in the self-care of diabetes that enables a diabetic to understand the disease and to manage its daily therapy.

Such a program must be prescribed by a Doctor. The program must be taught by a "qualified provider," which means a licensed Doctor or a certified, registered or licensed health care professional with expertise in diabetes management to whom the diabetic has been referred by a Doctor.

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

Coverage includes Medically Necessary visits to a "qualified provider" after the diabetic's Doctor has made an initial diagnosis of diabetes up to the maximum shown in the Schedule of Benefits and after the diabetic's Doctor has determined that a significant change in the diabetic's symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia {greater than 250 mg/dl on repeated occasions}, severe hypoglycemia {requiring the assistance of another person}, onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

Diabetic self-management education benefits are payable to the same extent as any other covered Sickness and subject to all of the terms and conditions of the Policy.

Home Health Care Expense Benefit

We will pay the Covered Expenses incurred for care and treatment rendered to a Covered Person by a Home Health Care Agency for the following Home Health Care Services:

1. Nursing care furnished by or under the supervision of a registered nurse;
2. Certified nurse aide service under the supervision of a registered nurse or a qualified therapist;
3. Physical therapy, occupational therapy, speech therapy and audiology; respiratory and inhalation therapy;
4. Medical social service by a qualified social worker licensed by the jurisdiction in which services are rendered;
5. Nutrition counseling by a nutritionist or dietician;
6. Home Health Aide services;
7. Medical appliance and equipment, drugs and medicines, and laboratory services;
8. Any diagnostic and therapeutic service, including surgical services, performed in a Hospital outpatient department, ambulatory surgical facility, Doctor's office, or any other licensed health care facility, to the extent such service would have been covered under the Policy, and provided that such service is delivered as part of the Home Health Care Plan.

Home Health Care Agency visits are limited to 40 visits in any continuous 12-month period. Services up to 4 hours by a Home Health Agency team will be considered as one Home Health Care Agency visit.

Benefit payments will be subject to any Deductible, Co-payment, Coinsurance rate, Benefit Maximum, Lifetime Aggregate Benefit Maximum, and Benefit Period shown in the Schedule of Benefits.

Definitions

"Home Health Aide" means a person who:

1. Provides care of a medical or therapeutic nature, or who provides Daily Living Services; and
2. Reports to and is under the direct supervision of a Home Health Care Agency.

DESCRIPTION OF BENEFITS (Continued)

ADDITIONAL BENEFITS (Continued)

Home Health Agency: means an organization, or its distinct part, that meets all these tests:

1. its' primary purpose is providing skilled nursing and other therapy for, and in the private homes of, persons recovering from an Injury or Sickness.
2. it is licensed or approved under any state or local standards that apply; it is run under policies established by a professional staff that includes Doctors and registered nurses.
3. its' services are supervised by a Doctor or registered nurse; it keeps clinical records on all patients.
4. it does not, except incidentally, provide care or treatment of the mentally ill or care of a custodial nature.

PRE-EXISTING CONDITION LIMITATION

“Pre-existing Condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months immediately preceding the Effective Date of the Insured Person's coverage under this Policy. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

The Pre-existing Condition Waiting Period is twelve (12) 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 twelve (12) 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 twelve (12) consecutive month period.

The Pre-existing Condition Waiting Period will be reduced by the aggregate period of Creditable Coverage of the Insured Person, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the coverage.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage of more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

The Pre-existing Condition Waiting Period will not apply:

- (a) To pregnancy.
- (b) In the case of an Insured Person who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage.
- (c) In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.
- (d) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured Person held Creditable Coverage, and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

The provisions of paragraphs (b) and (c) do not apply to an Insured Person after the end of the first 63-day period during all of which the Insured Person was not covered under any Creditable Coverage.

Definition:

“Creditable Coverage” means health benefits or coverage provided to a person pursuant to:

- (a) A group health plan;
- (b) A health benefit plan;
- (c) Part A or Part B of the Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395c et seq., also known as Medicare;
- (d) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec.1392s;
- (e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq.;
- (f) A medical care program of the Indian Health Service or of a tribal organization;
- (g) A state health risk pool;
- (h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seq.;

- (i) A public health plan. A public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in this plan, as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Services Act, 42 U.S.C. Sec. 300 gg(c)(1)(I);
- (j) A health benefit plan under insurance program established pursuant to 42 U.S.C. Sec. 2504(e);
- (k) The children's health insurance program established pursuant to 42 U.S.C. Sec 1397aa 1397jj, inclusive;
- (l) A short-term health insurance policy; or
- (m) A blanket accident and health insurance policy.

GENERAL POLICY EXCLUSIONS

The Policy does not provide coverage for loss caused by or resulting from:

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. Pre-existing Conditions as defined in this Policy
3. Injury sustained or Sickness contracted while in the 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;
4. 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 in excess of \$500;
5. 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;
6. Expenses incurred for Injury or Sickness for which benefits are paid under any Worker's Compensation or Occupational Disease Law;
7. 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 sound, natural teeth;
8. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits provision, when applicable;
9. Injury resulting from declared or undeclared war; or any act thereof;
10. 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;
11. Injury due to voluntary participation in a riot;
12. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
13. 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;
14. 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 Lasic or other vision procedures except as required for repair caused by a covered Injury;

GENERAL POLICY EXCLUSIONS (Continued)

15. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
16. Expenses for any service or supply not specified in this Policy as a covered service;
17. An amount of a charge in excess of the Usual and Customary Expense;
18. Services not Medically Necessary;
19. 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 scheduled airline maintaining regular published schedules on a regularly established route;
20. Treatment of mental or nervous disorders except as specifically provided;
21. Treatment of alcohol and substance abuse except as specifically provided;
22. Voluntary or elective abortion, except as specifically provided;
23. Illegal drugs.

NON-DUPLICATION OF BENEFITS LIMITATION

If benefits are payable under more than one (1) benefit provision contained in the Policy, benefits will be payable only under the provision providing the greater benefit.

EXCESS PROVISION

No benefit under this Policy is payable for any expense incurred for Injury or Sickness which is paid or payable by: (1) other valid and collectible insurance; or (2) under an automobile insurance policy.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.

CLAIM PROVISIONS

Notice of Claim: Written (or authorized electronic or telephonic) notice of a claim under the Policy must be given to the Administrator within 30 days after any loss covered by the Policy occurs, or as soon thereafter as is reasonably possible. The notice should identify the Covered Person and the Policy number.

Claim Forms: Upon receipt of a written notice of claim, the Administrator will send claim forms to the claimant within 15 days. If the forms are not furnished within 15 days, the claimant will satisfy the Proof of Loss requirements of the Policy by submitting written proof describing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written (or authorized electronic or telephonic) proof of loss must be furnished to the Administrator within 90 days after the date of loss. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided:

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy, other than for any periodic payments, will be paid within 30 days after the receipt of due written proof of loss; or the Insured, the Insured's assignee, health care professional, or health care facility will be notified that additional documentation is needed. All other benefits will be paid as soon as the required proof of loss is received.

Claims paid 30 or more days following the date of receipt of satisfactory proof of loss will be subject to the payment of interest at a rate of 9% per year. Interest is calculated from the 30th day following receipt of proof of loss until the date of the late payment. No interest payment is due for any amount of interest, which is less than \$1.00.

Payment of Claims: All benefits payable under the Policy shall be payable to the Covered Person or to his or her designated beneficiary or beneficiaries, or to his or her estate. If the Covered Person is a minor, benefits may be payable to the parents, guardian, or other person actually supporting him or her, or to a person or persons upon whom such minor is chiefly dependent for support and maintenance.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to \$1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

PREMIUMS

Premiums: The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes In Premium Rates: We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 consecutive months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium: The first Premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period: A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

GENERAL PROVISIONS

Entire Contract: The entire contract consists of the Policy (including any endorsements or amendments), and the signed application of the Policyholder. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Policy Effective Date: The Policy begins on the Policy Effective Date at 12:01 AM, Standard Time at the address of the Policyholder.

Policy Termination: We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium due date by giving 31 day advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us.

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 12:01 AM, Standard Time at the address of the Policyholder on the date of termination.

Assignment: At the request of the Covered Person or his or her parent or guardian, medical benefits may be paid to the provider of service. No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will end our liability to the extent of the payment.

Physical Examination and Autopsy: We have the right to have a Doctor of our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. Such examinations or autopsies will be at the expense of the Insurer.

Subrogation: We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

Right of Reimbursement: If a Covered Person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, Covered Person's parents if the Covered Person is a minor, or Covered Person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

GENERAL PROVISIONS (Continued)

Right of Recovery: If We make payments with respect to benefits payable under the Policy in excess of the amount necessary, We shall have the right to recover such payments. We shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, We shall have the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Examination of Records and Audit: We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after final termination of the Policy as they relate to the Premiums or subject matter of this insurance.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Incontestability. We cannot contest the validity of this Policy after two years from the date of issue except for non-payment of premiums. We cannot contest the validity of coverage with respect to a Participating Employer under this Policy after two years from the Participating Employer's Effective Date except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for two years while the Insured is alive. Any of the Insured's statements that we contest must be in written application signed by the Insured.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered, is hereby amended to conform to the minimum requirements of those statutes.

Not in Lieu of Workers' Compensation. This Policy is not a Workers' Compensation policy. It does not provide any Worker's Compensation benefit.