

## STUDENT ACCIDENT AND SICKNESS CERTIFICATE

GROUP POLICYHOLDER:	THE GROUP AND BLANKET ACCIDENT AND HEALTH INSURANCE TRUST
GROUP POLICY NUMBER:	AH27261-006
PARTICIPATING ORGANIZATION:	STUDENT OSTEOPATHIC MEDICAL ASSOCIATION - SOMA
YOUR COVERAGE NUMBER:	US003891
EFFECTIVE DATE:	9/1/2010
TERMINATION DATE:	8/31/2011
TERM OF COVERAGE:	12 MONTHS

We agree, subject to all terms, provisions, conditions, exclusions and limitations of the policy to pay the benefits provided for any covered loss under the policy.

This coverage is issued in consideration of the enrollment form and payment of premiums when due.

### ENDORSEMENTS AND RIDERS ATTACHED

The following are attached to and form a part of this Certificate:

AH27251

AH27256

AH27263

AH27328

The **primary insured** is referred to throughout as "you" or "your". Wherever a masculine pronoun is used, it includes the feminine also unless the context clearly indicates the contrary. A singular term includes the plural unless the context clearly indicates otherwise. Words that are in **boldface** (other than captions) have a special meaning and are defined in the Definitions section.

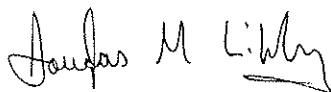
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**(This Certificate Does Not Cover a Primary Insured for Any Injury Covered by another Student Accident Insurance Policy)**

### NON-RENEWABLE TERM INSURANCE

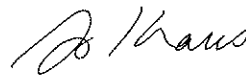
**THIS CERTIFICATE WILL NOT BE RENEWED AT THE END OF THE TERM OF COVERAGE.**

Signed for **United States Fire Insurance Company** By:



Douglas M. Libby

Chairman and CEO



James Kraus

Secretary

## PART I. SCHEDULE OF BENEFITS -- PLAN 2

<b>Maximum Benefit</b>	<b>\$100,000 per Injury or Sickness</b>
<b>Deductible</b>	<b>\$2,000 Policy Year – In-Network Preferred Provider \$4,000 Policy Year – Out-of-Network</b>
<b>Coinsurance</b>	<b>80% of Preferred Allowance In-Network 60% of Usual, Reasonable &amp; Customary Charges, (URC), or as shown below</b>

If the amount paid by the **covered person** in any one policy year reaches the out-of-pocket Maximum of \$8,000 per **injury or sickness**, we will then pay 100% of the Preferred Allowance for Preferred Providers or 100% of URC of additional **covered expenses for each injury or sickness** up to the Policy Year Maximum of \$100,000. The Deductible is not included in the out-of-pocket Maximum.

If you receive care within the Network from a Preferred Provider any **covered expenses** will be paid at the In-Network level of benefits. If an In-Network Provider is not available in your Network Area, benefits will be paid at the level of benefits shown as In-Network Preferred Provider benefits. If the Covered Medical Expense is incurred due to an emergency treatment, benefits will be paid at the In-Network Preferred Provider level of Benefits. In all other situations, reduced, or lower benefits will be provided when an Out-of-Network provider is used. The Benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

Benefits will be paid up to the Maximum Benefit for each service scheduled below. After the Deductible has been satisfied, benefits will be paid as listed for the Provider selected.

<b>Inpatient</b>	<b>In-Network Preferred Provider</b>	<b>Out-of-Network/Non-Preferred Provider</b>
<b>Room &amp; Board / Hospital Miscellaneous</b>	80% of Preferred Allowance	60% of Semi-Private Room Rate
<b>Intensive Care Expenses</b>	Paid under Room & Board/ Hospital Miscellaneous Benefit	Paid under Room & Board/ Hospital Miscellaneous Benefit
<b>Surgeon's Fees</b>	80% of Preferred Allowance	60% of UCR
<b>Anesthetist</b>	25% of the Surgery Allowance	25% of the Surgery Allowance
<b>Assistant Surgeon</b> <i>secondary assistant surgeon fees are paid at 50% of Primary</i>	80% of Preferred Allowance	60% of UCR
<b>Registered Nurse's Services</b> <i>Private duty nursing care</i>	80% of Preferred Allowance	60% of UCR
<b>Physician's Visits</b>	80% of Preferred Allowance	60% of UCR
<b>Pre-Admission Testing</b>	80% of Preferred Allowance	60% of UCR
<b>Physiotherapy</b>	Paid under Room & Board/ Hospital Miscellaneous Benefit	Paid under Room & Board/ Hospital Miscellaneous Benefit
<b>Psychotherapy</b>	80% of Preferred Allowance	60% of UCR

**Routine Newborn Care**  
*48 hours vaginal /9 6 hours  
 caesarean*

Paid the same as any other Sickness

Paid the same as any other  
 Sickness

<b>Outpatient</b>	<b>In-Network Preferred Provider</b>	<b>Out-of-Network/Non-Preferred Provider</b>
<b>Surgeon's Fees</b>	80% of Preferred Allowance	60% of UCR
<b>Day Surgery Miscellaneous</b>	80% of Preferred Allowance	60% of UCR
<b>Assistant Surgeon</b> <i>secondary assistant surgeon fees are paid at 50% of Primary</i>	80% of Preferred Allowance	60% of UCR
<b>Anesthetist</b>	25% of the Surgery Allowance	25% of the Surgery Allowance
<b>Physician's Visits</b>	80% of Preferred Allowance	60% of UCR
<b>Outpatient Miscellaneous Benefits</b>	80% of Preferred Allowance	60% of UCR
<b>Medical Emergency Expenses</b>	80% of Preferred Allowance	60% of UCR
<b>Diagnostic X-ray Services</b>	80% of Preferred Allowance	60% of UCR
<b>Laboratory Services</b>	80% of Preferred Allowance	60% of UCR
<b>Radiation Therapy and Chemotherapy</b>	80% of Preferred Allowance	60% of UCR
<b>Injections</b>	80% of Preferred Allowance	60% of UCR
<b>Tests and Procedures</b>	80% of Preferred Allowance	60% of UCR
<b>Psychotherapy</b>	50% of Preferred Allowance	50% of UCR

**SCHEDULE OF BENEFITS (Continued)**

<b>Outpatient</b>	<b>In-Network/Preferred Provider</b>	<b>Out-of-Network/Non-Preferred Provider</b>
<b>Physiotherapy</b>	80% of Preferred Allowance	60% of UCR
<b>Other Additional Benefits</b>	<b>In-Network/Preferred Provider</b>	<b>Out-of-Network/Non-Preferred Provider</b>
<b>Ambulance Services</b>	80% of URC	80% of URC
<b>Braces and Appliances Durable Medical Equipment</b>	80% of URC	80% of URC
<b>Dental Treatment Made necessary by Injury to Natural Teeth</b>	80% of URC	80% of URC
<b>Needle Stick</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Maternity</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Elective Abortion</b>	No Benefits	No Benefits
<b>Complications of Pregnancy</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Consultant Physician Fees</b>	80% of Preferred Allowance	80% of UCR
<b>Cat Scan / MRI</b>	80% of Preferred Allowance	60% of UCR
<b>Wellness Benefit Wellness expense for the Insured and Dependents over the age of 18. Benefits include one examination/routine physical and one HIV/syphilis test each Policy Year, includes pre/post test counseling. For men, routine physical examination includes the office visit charge and a gonorrhea/Chlamydia test, a hemoglobin and urine test. For women, examination includes the office visit charge, pap smear, gonorrhea, Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test.</b>	80% of Preferred Allowance	60% of UCR

**SCHEDULE OF BENEFITS (Continued)**

<b>Other Additional Benefits</b>	<b>In-Network Preferred Provider</b>	<b>Out-of-Network Non-Preferred Provider</b>
<b>Prescription Drugs</b> <i>\$2,500 maximum per policy year</i>	80% of Preferred Allowance	60% of UCR
<b>Home Health Services</b>	80% of Preferred Allowance	60% of UCR
<b>Alcoholism Benefit</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Substance Drug Abuse</b>	Paid under the Psychotherapy Benefit	Paid under the Psychotherapy Benefit
<b>Accidental Death &amp; Dismemberment</b>	\$5,000 - \$10,000 Maximum	\$5,000 - \$10,000 Maximum
<b>Intercollegiate Sports</b>	No Benefits	No Benefits

If you have Other Insurance:  **Excess Insurance**  **Primary Insurance**  **Coordination of Benefits**

**Excess Insurance** - Your benefits are payable for **covered expenses** not otherwise covered and payable by any other plan providing medical expense benefits. If there are no other valid and collectible benefits available from any other source, this plan will pay the **covered expenses** up to the limits of the policy. If there are other valid and collectible benefits available from any other source We will pay a minimum benefit amount of \$100 and thereafter We will pay any excess amount unpaid from Your primary insurance.

**Primary Insurance** - Your benefits are payable for **covered expenses** regardless of any other amounts payable by any other plan providing medical expense benefits.

**Coordination of Benefits** – See Endorsement Attached.

**NOTES:**

- We do not pay benefits for the amount of **covered expenses** paid by you as your **coinsurance** amount.
- **Covered expenses** will be paid under the inpatient benefits for surgery and under the outpatient benefits for surgery, but not both for the same or related procedure.

## Part II. DEFINITIONS

1. **Accident** means an event which (a) causes Injury to one or more Covered Persons; and (b) occurs while coverage is in effect for the Covered Person.
2. **Coinsurance** means the percentage amount of **covered expenses** for which you are responsible for any medical service or supply. The **coinsurance** is shown in the Schedule. We will pay the remaining amount of **covered expenses**, subject to the maximum amount for specific services and the maximum benefit for all services.
3. **Complications of pregnancy** means:
  - a. Conditions whose diagnosis is distinct from but adversely affected or caused by pregnancy and which require a **hospital stay** (when pregnancy is not terminated). Such conditions include, but are not limited to, acute nephritis; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; and similar conditions of comparable severity; or
  - b. Non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; and spontaneous termination of a pregnancy during a period of gestation when a viable birth is not possible.

**Complications of pregnancy** do *not* include:

- False labor;
  - Occasional spotting;
  - **Doctor**-prescribed rest during pregnancy;
  - Morning sickness; or
  - Similar conditions associated with a difficult pregnancy that are not classified as a complication of pregnancy.
4. **Covered expenses** means charges:
    - a. Not in excess of **usual, reasonable and customary** charge;
    - b. Not in excess of the maximum benefit amount payable per service as shown in the Schedule;
    - c. Made for medical services and supplies not excluded under the policy;
    - d. Made for services and supplies which are **medically necessary**; and
    - e. Made for medical services specifically included in the Schedule.
  5. **Covered person** means you and your eligible **spouse** and **dependents** covered under the policy. The proper premium payment must be made to be covered under the policy.
  6. **Deductible** means the amount of **covered expenses** paid on behalf of a **covered person** before benefits are payable under the policy. The **deductible** amount is shown in the Schedule.
  7. **Dependent** means your unmarried child who:
    - a. Has his principal residence with you;
    - b. Chiefly relies on you for support and maintenance; and
    - c. Is within the following age groups unless otherwise shown in the Schedule:
      - 1) Under 19 years of age;
      - 2) 19 but less than 25 years of age and enrolled in a School as a full time student; or
      - 3) 19 or more years of age, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a **dependent** under (1) or (2) above. We may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

"Child" can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

8. **Doctor** means a licensed practitioner of the healing arts acting within the scope of his license. **Doctor** does not include:
  - a. You;
  - b. Your **spouse, dependent, parent, brother, or sister**; or
  - c. A person who ordinarily resides with you.

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9. **Hospital** means an institution:
- Operated pursuant to law;
  - Primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
  - Under the supervision of a staff of **doctors**;
  - Providing 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
  - With medical, diagnostic and treatment facilities, and with major surgical facilities;
    - On its premises; or
    - Available on a prearranged basis; and
  - Charging for its services.

**Hospital** does *not* include a clinic or facility for:

- Convalescent, custodial, educational or nursing care;
- The aged, drug addicts or alcoholics; or
- Rehabilitation.

10. **Hospital stay** means a **medically necessary** overnight confinement in a **hospital** when room and board and general nursing care are provided and a per diem charge is made by the **hospital**.
11. **Injury** means bodily harm resulting, directly and independently of disease or bodily infirmity, from an accident. All **injuries** to the same person sustained in one accident, including all related conditions and recurring symptoms of **injuries** will be considered one **injury**.
12. **Intensive care** means:
- A specifically designated facility of the **hospital** that provides the highest level of medical care; and
  - Restricted to those patients who are critically ill or injured.

Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. It must be:

- Permanently equipped with special life-saving equipment for the care of the critically ill or injured; and
- Under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Intensive Care Unit.

**Intensive care** does *not* mean any of these step-down units:

- Progressive care;
- Sub-acute intensive care;
- Intermediate care units;
- Private monitored rooms;
- Observation units; or
- Other facilities not meeting the standards for **intensive care**.

13. **Medical emergency** means the occurrence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in:
- placing one's health (for a pregnant woman this includes the health of the newborn) in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any body organ or part.

Expenses incurred for **medical emergency** will be paid only for an **sickness** or **injury** fulfilling the above conditions. These expenses will not be paid for minor **sickness** or minor **injuries**.

14. **Medically necessary** means those services or supplies provided or prescribed by a **hospital** or **doctor**:
- Essential for the symptoms and diagnosis or treatment of the **sickness** or **injury**;
  - Provided for the diagnosis, or the direct care and treatment of the **sickness** or **injury**;
  - In accordance with the standards of good medical practice;
  - Not primarily for your convenience or that of your **doctor**; and
  - That are the most appropriate supply or level of service that can safely be provided.

15. **Natural teeth** means natural teeth or teeth where the major portion of the individual tooth is present, regardless of fillings or caps, and is not carious, abscessed, or defective.

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16. **Negative X-ray** means an X-ray that shows the absence of a fracture, pathology, or disease.
  17. **Nurse** means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).
  18. **Participating institution** means the college or university you attend during your **term of coverage**.
  19. **Physiotherapy** means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a **doctor**.
  20. **Policyholder** means the entity to which the policy is issued. The **policyholder** is shown on the first page of the policy.
  21. **Positive X-Ray** means an X-ray that shows the presence of a fracture, pathology, or disease.
  22. **Prescription** means any authorization, including authorized refills, issued by a **doctor** for dispensing medication for the purpose and in the amount specified.
  23. **Prescription drug** means:
    - a. A legend drug;
    - b. A compound medication when at least one ingredient is a prescription legend drug;
    - c. Any other drug which under applicable state law may only be dispensed by **prescription**, including injectable insulin; or
    - d. Drugs and medications dispensed by a licensed pharmacist that are not specifically excluded by other provisions applicable to this coverage.
  24. **Primary insured** means you.
  25. **Psychotherapy** means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.
  26. **Sickness** means illness or disease diagnosed during the **term of coverage** under the Policy for the **covered person**. **Sickness** includes normal pregnancy and **complications of pregnancy**. All related conditions and recurring symptoms of **sickness** will be considered one **sickness**.
  27. **Spouse** means your lawful **spouse**.
  28. **Term of coverage** means the period of coverage beginning with your Effective Date and ending upon completion of a trimester, semester or other measure of an academic session determined by the **participating institution**.
  29. **Usual, reasonable and customary** means:
    - a. Charges and fees for medical services or supplies that are the lesser of:
      1. The usual charge by the provider for the service or supply given; or
      2. The average charged for the service or supply in the area where service or supply is received;and
    - b. Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

### **PART III. WHEN COVERAGE BEGINS AND WHEN COVERAGE ENDS**

**Effective Date** - Your Effective Date is the later of the Effective Date of the policy or the date we receive the required premium.

1. The Effective Date for your eligible **spouse** or **dependents** enrolled with you is your Effective Date provided we receive the required premium for **spouse** or **dependent**.

If a **spouse** or **dependent** becomes eligible after your Effective Date, you have at least 30 days from the date such **spouse** or **dependent** first becomes eligible to enroll them and pay the applicable premium.

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## 2. Automatic Coverage for Newly – Acquired Dependents

A newborn child will be automatically covered for the first 31 days after birth. An adopted child or child placed with you in anticipation of adoption will be automatically covered for 31 days from the date of placement. The automatic coverage of a newborn child or child placed for adoption will end on the 32<sup>nd</sup> day after birth or placement.

Coverage for such a child will be the same as any other **dependent**, including medically diagnosed congenital defects, birth abnormalities, premature birth care and nursery care.

You will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage you must, within the 31 days after the date of birth, adoption, or placement for adoption:

- a. Enroll such **dependent**; and
- b. Pay the required additional premium for the continued coverage.

If you do not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth, adoption, or placement for adoption.

**Coverage Ends** - Your coverage ends on the earliest of the following:

1. The date you cease to be eligible for coverage; or
2. The end of your **term of coverage**.

Your **spouse** or **dependent** coverage will end at the earliest of:

1. The end of the period for which the premium is paid for such **spouse** or **dependent** coverage;
2. The date a **spouse** or **dependent** is no longer eligible for coverage; or
3. The end of your **term of coverage**.

## PART IV. TIME LIMITS FOR COVERED LOSS

**Covered expenses** will be paid as shown in the Schedule for loss:

1. Due to **injury** when:
  - a. The accident causing the **injury** occurs before the end of your **term of coverage**;
  - b. Treatment by a **doctor** begins within 30 days after the date of the accident causing **injury**;
  - c. Treatment and services received are included under the definition of **covered expenses**.
  
2. Due to **sickness** of a **covered person** provided:
  - a. Treatment by a **doctor** begins during that person's **term of coverage**;
  - b. Treatment and services received are included under the definition of **covered expenses**.

## PART V. MEDICAL EXPENSE BENEFITS

We will pay benefits for **covered expenses** incurred by a **covered person** for loss due to **sickness** or **injury**, less any **deductible** and subject to:

1. The maximum benefit for all services as shown in the Schedule;
2. The maximum amount for specific services as shown in the Schedule; and
3. Any **coinsurance** amount shown in the Schedule, or any endorsement or rider attached to the Evidence of Coverage.

**Covered expenses** are considered incurred when the covered service is rendered, provided there is a charge made for such service.

We provide payment for services, procedures and supplies that are **medically necessary**. No benefits will be paid for expenses determined not to be **medically necessary**, including any or all days of **hospital stay**. The total payable for all **covered expenses** will not exceed the maximum benefit shown in the Schedule. Also read the DEFINITIONS section carefully. No benefits will be paid for services designated as "No Benefits" in the Schedule.

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## **A. INPATIENT COVERED EXPENSES INCLUDE:**

### **1. Hospital Services:**

#### **Room and Board Expense:**

- Daily semi-private room rate for a **hospital stay**; and
- General nursing care provided and charged for by the **hospital**.

#### **Intensive Care**

#### **Miscellaneous Expenses:**

- During a **hospital stay**; or
- As a precondition for a **hospital stay**.

Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; 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.

#### **Physiotherapy**

### **Surgery Services:**

#### **Surgeon**

#### **Assistant Surgeon**

#### **Anesthetist**

#### **Nurses:**

- a. Private duty nursing care only;
- b. During a **hospital stay**;
- c. Ordered by a **doctor**; and
- d. **Medically necessary**.

General nursing care provided by the **hospital** is not covered under this benefit.

- 3. Doctor's Visits** during a **hospital stay**. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.
- 4. Preadmission Testing** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the Hospital Miscellaneous Expenses benefit.
- 5. Psychotherapy** for the treatment of a mental or emotional disorder or of related bodily illness by psychological means where the psychotherapy is administered by a **doctor**.

## **B. OUTPATIENT COVERED EXPENSES INCLUDE:**

### **1. Surgery Services:**

#### **Surgeon**

#### **Anesthetist**

**Miscellaneous for Day Surgery** benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies.

- 2. Miscellaneous Hospital and Doctor** services payable as shown in the Schedule.
- 3. Doctor's Visits** limited to one visit per day. Benefits do not apply when related to surgery or **physiotherapy**.
- 4. Physiotherapy** limited to one visit per day.
- 5. Medical Emergency** as defined. Benefits will be paid as shown in the Schedule.
- 6. Diagnostic X-ray Services** as shown in the Schedule. Separate maximums apply to **positive** and **negative X-rays**. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000-79999 inclusive.
- 7. Radiation Therapy**

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8. **Laboratory Procedures** are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
  9. **Tests and Procedures:**
    - a. Diagnostic services and medical procedures;
    - b. Performed by a **doctor**;
    - c. Excluding Doctor's Visits; Physiotherapy; X-rays; and Laboratory Procedures.
  10. **Injections:**
    - a. When administered in the **doctor's** office; and
    - b. Charged on the **doctor's** statement.
  11. **Prescription Drugs**
  12. **Chemotherapy**

## **C. OTHER SERVICES**

1. **Ambulance Services**
2. **Braces and Appliances:**
  - a. When prescribed by a **doctor**; and
  - b. When a written prescription accompanies the claim when submitted.

Braces and appliances include durable medical equipment which:  
Is primarily and customarily used to serve a medical purpose,  
Can withstand repeated use, and  
Is not generally useful to a person in the absence of **sickness** or **injury**.

No benefits will be paid for rental charges in excess of purchase price.

3. **Consulting Physician** 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 both on the same day.
4. **Dental Treatment** performed by a **doctor** and made necessary by **injury** to **natural teeth**.

## **PART VI. EXCLUSIONS AND LIMITATIONS**

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

1. Any Sickness or Injury, as defined, that was initially diagnosed, treated or recommended for treatment prior to the Term of Coverage for a Covered Person, unless continuous coverage is applied;]
2. Biofeedback - services and supplies related to biofeedback;
3. Circumcision, except if medically necessary due to Injury illness, disease, or functional congenital disorder;
4. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; hirsutism; nonmalignant warts, moles and lesions;
5. Dental treatment, except [for accidental Injury to Sound, Natural Teeth;
6. Elective abortion;
7. Elective surgery and elective treatment;
8. Except for **Injury** sustained while:
  - a. Participating in any interscholastic, club, intercollegiate, or professional organized sport, contest or competition unless specifically list in the Schedule;
  - b. Traveling to or from such sport, contest or competition as a participant; or

- 
- c. While participating in any practice or conditioning program for such sport, contest or competition;
9. Eye examinations, eye refractions, eyeglasses, prescriptions or fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, vision correction surgery, unless payable as a **covered expense** associated with a **sickness** or **injury** covered by the policy;
  10. Hearing examinations or hearing aids, or other treatment for hearing defects and problems, unless payable as a **covered expense** associated with an **injury** covered by the policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
  11. Immunizations services and supplies related to immunizations, except as specifically provided in a benefit section; preventive medicines or vaccines, except where required for treatment of a covered injury;
  12. **Injury** caused by, contributed to, or resulting from, the use of alcohol, intoxicants, controlled substance, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the person's **doctor**; intoxication is defined and determined by the laws of the state where the loss or cause of the loss was incurred;
  13. Injury or Sickness for which benefits are paid under any loss covered by state or Federal Worker's Compensation Law, employers liability law, Occupational Disease Law, or similar laws or act;
  14. Suicide or attempted suicide while sane or insane (including drug overdose); or Intentionally self-inflicted **injury**;
  15. Learning disabilities;
  16. Organ transplants that are experimental;
  17. Prescription Drug Services - no benefits will be payable for:
    - a. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
    - b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    - d. Products used for unapproved cosmetic indications;
    - e. Drugs used to treat or cure baldness, and anabolic steroids used for body building;
    - f. Anorectics - drugs used for the purpose of weight control;
    - g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    - h. Growth hormones, except if Medically Necessary for treatment of growth disorder as determined by the **doctor**; or
    - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
  18. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception;]premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery;
  19. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the Policy
  20. Services provided normally without charge by the Health Service of the Policyholder or services covered or provided by the student health fee;
  21. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia;]temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;
  22. Sleep disorders, supplies, treatment, or testing relating to sleep disorders;

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23. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; other than as specifically provided in the Policy;
  24. Treatment in a military or Veterans Hospital or a **hospital** contracted for or operated by a national government or its agency unless:
    - a) The services are rendered on an **medical emergency** basis; and
    - b) A legal liability exists for the charges made on behalf of a **covered person** for the services given in the absence of insurance.;
  26. War or any act of war, declared or undeclared, or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);
  27. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, surgical weight loss procedures, surgery for removal of excess skin or fat and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

**Continuous Coverage** - If a **covered person** is continuously covered under the policy offered through your **participating institution** they will be covered for any **sickness** diagnosed or **injury** sustained while so covered. If a **covered person** is enrolled for coverage offered through your **participating institution** within 63 days of the end of any preceding company's policy you will be considered to have maintained continuous coverage, except for expense that are the liability of the previous policy. Coverage cannot be considered continuous if a break in enrollment of more than 63 days occurs.

## PART VII. GENERAL PROVISIONS

**Incontestability** - If an enrollment form of a **primary insured** is required, the enrollment form of any **primary insured**, at our option, may also be made a part of the contract.

All statements made by you are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to you; or, in the event of your death or incapacity, your beneficiary or representative.

**Premiums** - All premiums are payable in advance for each **term of coverage** in accordance with our premium rates. There are no pro-rata or reduced premium payments.

If you report for active duty in the armed forces, we will refund a pro rata premium upon receipt of proof of service. This does not include Reserve or National Guard duty for training.

There will be no refunds to international students who cancel coverage under the policy, unless the person returns to his home country.

Premium adjustments involving return of unearned premiums to the **participating institution** will be limited to a period of 12 months immediately preceding the date of receipt by us of evidence that adjustments should be made. Premiums are payable to us.

**Notice of Claim** - Written notice must be given to us within 90 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given to our authorized representative. Notice should include the **participating institution's** name and number and the **primary insured's** name and address.

**Claim Forms** - Upon receipt of a notice of claim, we will furnish to the claimant such forms as we usually furnish for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

**Proof of Loss** - Written proof of loss must be furnished to us in the case of a claim for loss for which the policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

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In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss. If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

**Time of Payment of Claim** - Benefits due under the policy for a loss, other than a loss for which the policy provides installments, will be paid immediately upon receipt of due written proof of such loss.

**Payment of Claims** - All or a portion of any indemnities provided by the policy may, at our option, and unless you request otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the **hospital** or person rendering such service. Otherwise, accrued indemnities will be paid to you or to your estate. Any payment so made shall discharge our obligations to the extent of the amount of benefits so paid.

**Physical Examination and Autopsy** - We will pay the cost and have the right to have the person examined as often as reasonably necessary while the claim is pending. We have the right, at our expense, to secure a second opinion regarding treatment or hospitalization. Failure of a person to present himself for examination by a **doctor** when requested will allow us to:

- Withhold any payment for **covered expenses** until such examination is performed and a **doctor's** report received; and
- Deduct from any amounts otherwise payable any amount we paid to a **doctor** for the examination when the person fails to appear.

Said deduction shall be made with the same force and effect as a **deductible** herein defined.

We can have an autopsy made at our expense unless prohibited by law.

**Legal Action** - No action at law or in equity shall be brought to recover benefits under the policy less than 60 days after written proof of loss has been furnished as required by the policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

**Subrogation** - When benefits are paid to or for a person under the terms of the policy, we shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such person against any person who might acknowledge liability or found legally liable by a Court of competent jurisdiction for the **sickness** or **injury** that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by us of the benefits we have paid for such hospitalization and treatment and we shall pay fees and costs associated with such recovery.

The person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.

**Right of Recovery** - Payments made by us which exceed the **covered expenses** (after allowance for **deductible** and **coinsurance** clauses, if any) payable hereunder shall be recoverable by us from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered **injury** as their liability may appear.

**Appeal** - If we deny a claim for benefits, we will give you a written explanation. If you feel we are wrong, you have the right to appeal our decision. You must do this in writing.

**Waiver of Rights** - If we fail to enforce or correctly apply any provision of the policy, this will not affect our right to enforce or correctly apply such provision at a later date. It will not affect our right to enforce any other provision of the policy.

**Conformity of Law** - Any provision of this policy which, on its Effective Date, is in conflict with the laws of the state in which the policy is delivered or issued for delivery, is considered amended to conform to the applicable requirements of such state.

## SCHEDULE OF BENEFITS *(Continued)*

**“Preferred Providers”** are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

The availability of specific providers is subject to change without notice. You should always confirm that a Preferred Provider is participating at the time services are required.

**“Preferred Allowance”** means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

**“Out of Network”** providers have not agreed to any prearranged fee schedules. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

**“Allowable Charges”** means the United States Fire Insurance Company’s allowance for a specified Covered Medical Expense or the Provider’s charge for the service, whichever is less.

Regardless of the provider, you are responsible for the payment of your Deductible. You must satisfy your Deductible before benefits are paid. We will pay according to the benefit limits in the Schedule of Medical Expense Benefits.

**United States Fire Insurance Company**  
5 Christopher Way, Eatontown, NJ 07724

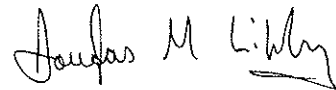
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**AMENDATORY ENDORSEMENT**

This Amendatory Endorsement is attached to and made a part of the Policy/Certificate. The provisions of this Amendatory Endorsement are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated. In consideration of issuance, the Policy/Certificate is hereby amended and modified, as follows:

The Effective Date for New Enrollees is hereby amended to 8/1/2010. Coverage will be in force as of 8/1/10 at 12:01 a.m., for New Enrollees.

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.



Douglas M. Libby  
Chairman and CEO

## United States Fire Insurance Company

5 Christopher Way, Eatontown, NJ 07724

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### AMENDATORY ENDORSEMENT

This Amendatory Endorsement is attached to and made a part of the Policy/Certificate. The provisions of this Amendatory Endorsement are effective on the Effective Date and will expire concurrently with the Policy/Certificate, unless otherwise terminated. In consideration of issuance, the Policy/Certificate is hereby amended and modified, as follows:

#### I. Applicable to Illinois Residents Only:

##### INPATIENT ALCOHOLISM TREATMENT BENEFIT

Benefits will be paid the same as any other **sickness** for inpatient alcoholism treatment. Benefits shall be subject to all **deductible**, copayment, **coinsurance**, limitations, or any other provisions of the Certificate

##### CERVICAL CANCER SCREENING TEST BENEFIT

Benefits will be paid the same as any other **sickness** for an annual Cervical smear or Pap smear test.

Benefits shall be subject to all **deductible**, copayment, **coinsurance**, limitations, or any other provisions of the Certificate.

##### COLORECTAL CANCER SCREENING

Benefits are payable on the same basis as any other **sickness** for colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a **doctor** in accordance with guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

##### DIABETES BENEFIT

**Diabetes** – Benefits are payable on the same basis as any other **sickness** for the following:

1. Outpatient diabetes self-management training, which includes:

The services of a **doctor** for up to three (3) Medically Necessary visits upon an initial diagnosis of diabetes;

The services of a **doctor** for up to two (2) Medically Necessary visits upon a determination by the Covered Person's **doctor** that a significant change in the person's symptoms or medical condition has occurred which requires a significantly different self-management regime; and  
*Medical nutritional counseling and instructions, and instructions on the proper use of diabetes equipment and supplies shall be provided or covered as part of the training.*

2. The following equipment when **medically necessary** and prescribed by a **doctor**:

blood glucose monitors, including those designed to be used by, or adapted for, the legally blind;  
insulin cartridges, including those designed to be used by, or adapted for, the legally blind;  
lancets and lancet devices; and  
regular foot exams.

3. For the following **medically necessary** pharmaceuticals and supplies when received on an inpatient basis, and prescribed by a **doctor**:

Insulin;  
syringes and needles;  
test strips for glucose monitoring;  
FDA approved oral agents used to control blood sugar; and  
glucagon emergency kits.

Diabetes benefits, as outlined above, are subject to the deductible, coinsurance, and Aggregate Maximum Amount on the same basis as any other Sickness.

### **GENERAL ANESTHESIA BENEFIT**

Benefits will be payable on the same basis as any other **sickness** for general anesthesia and associated facility charges for dental procedures rendered in a **hospital** or ambulatory surgical treatment center.

Benefits are only payable for **covered persons** if any of the following applies:

the **covered person** is a child age 6 or under;

the **covered person** has a medical condition that requires hospitalization or general anesthesia for dental care; or

the **individual** is disabled.

"Disabled" as used in this benefit means a person, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

It is attributable to a mental or physical impairment or combination of mental and physical impairments. It is likely to continue.

It results in substantial functional limitations in one or more of the following areas of major life activity:

self-care;

receptive and expressive language;

learning;

mobility;

capacity for independent living; or

economic self-sufficiency.

### **MAMMOGRAPHY BENEFIT**

Benefits are payable on the same basis as any other sickness for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer within the provisions of the policy, contract, or certificate. The coverage shall be as follows:

A baseline mammogram women 35 to 39 years of age.

An annual mammogram for women 40 years of age or older.

### **OSTEOPOROSIS TESTING BENEFIT**

**Osteoporosis Testing** - coverage for medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.

### **PAP SMEAR BENEFIT**

**Pap Smear** – coverage for an annual cervical smear or Pap smear test for female insureds.

### **PRENATAL HIV TESTING BENEFIT**

Coverage for prenatal HIV testing ordered by an attending physician licensed to practice medicine in all its branches, or by a physician assistant or advanced practice registered nurse who has a written collaborative agreement with a collaborating physician that authorizes these services, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

### **PROSTATE TESTS BENEFIT**

Coverage is provided for an annual digital rectal examination and a prostate-specific antigen test, for male insureds upon the recommendation of a physician licensed to practice medicine in all its branches for:

asymptomatic men age 50 and over;

African-American men age 40 and over; and

men age 40 and over with a family history of prostate cancer.

### **RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY BENEFIT**

Coverage is provided for prosthetic devices or reconstructive surgery incident to the mastectomy.

Coverage for breast reconstruction in connection with a mastectomy shall include:

reconstruction of the breast upon which the mastectomy has been performed;

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

### **CONTRACEPTIVES BENEFIT**

Benefits are payable on the same basis as any other **sickness** for outpatient prescription drugs and outpatient contraceptive services and devices approved by the Food and Drug Administration. "Outpatient contraceptive service" means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

### **SERIOUS MENTAL ILLNESS COVERAGE RIDER**

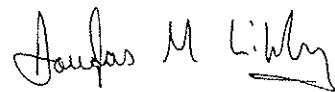
This Rider is attached to and made part of the policy as of the Effective Date. It is subject to all of the provisions, limitations and exclusions of the policy except as specifically modified by this Rider.

Benefits will be payable on the same basis as any other **sickness** for **Covered Persons** for treatment of serious mental illness.

"Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- (A) schizophrenia;
- (B) paranoid and other psychotic disorders;
- (C) bipolar disorders (hypomanic, manic, depressive, and mixed);
- (D) major depressive disorders (single episode or recurrent);
- (E) schizoaffective disorders (bipolar or depressive);
- (F) pervasive developmental disorders;
- (G) obsessive-compulsive disorders;
- (H) depression in childhood and adolescence; and
- (I) panic disorder.

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

A handwritten signature in black ink that reads "Douglas M. Libby". The signature is written in a cursive style with a prominent initial "D" and a stylized "L".

Douglas M. Libby  
Chairman and CEO

## **MENTAL AND NERVOUS DISORDERS COVERAGE RIDER**

This Rider is attached to and made part of the policy as of the Effective Date. It is subject to all of the provisions, limitations and exclusions of the policy except as specifically modified by this Rider.

If the **participating institution** selects this coverage and pays the required additional premium, the following coverage will apply during the **term of coverage**:

We will pay for the care and treatment of **mental or nervous disorders** for inpatient and outpatient care.

Inpatient services must be:

1. Rendered in a **hospital** or **treatment facility**; and
2. Under the direction of a **doctor**.

Outpatient services must be:

1. Provided by a **doctor**; or
2. Rendered at a **treatment facility** under the direction of a **doctor**.

### **DEFINITIONS**

**Mental or nervous disorder** means a **sickness** that is a mental, emotional or behavioral disorder. All diagnoses classified as a "Mental Disorder" according to the ICD-9 (International Classification of Diseases, 9th Revision, codes 290 through 319 inclusive) are considered one **sickness**.

**Treatment Facility** means a facility that is properly licensed and operating under applicable state laws and regulations to provide inpatient and/or outpatient services for **mental and nervous disorders**. It may be part of a **hospital**, or operating on its own. Inpatient services consist of 24-hour-a-day nursing services, supervision by a doctor and daily maintenance of patient records.

No additional benefits will be paid under any other Medical Expense Benefits of the policy.

The benefit amounts specific to this Rider are shown in the Schedule.

### **ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED**

This rider is part of the policy and takes effect with respect to each **primary insured** on the Effective Date of the his **term of coverage**. This rider will cover a **primary insured's spouse** and any other **dependent** when properly enrolled and the required premium is paid.

## UNITED STATES FIRE INSURANCE COMPANY

5 Christopher Way, Eatontown, NJ 07724

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### SUBSTANCE ABUSE COVERAGE RIDER

This Rider is attached to and made part of the policy as of the Effective Date. It is subject to all of the provisions, limitations and exclusions of the policy except as specifically modified by this Rider.

If the **participating institution** selects this coverage and pays the required additional premium, the following coverage will apply during the **term of coverage**:

Benefits for the treatment of substance abuse will be paid in the same manner as those paid for any other illness. A **doctor** must certify the **covered person** is suffering from substance abuse as defined and treatment must be recommended and monitored by the **doctor**. Benefits are subject to the following limitations:

**Inpatient** - We will pay benefits for confinement in a **hospital** or **residential facility**, up to the benefit levels shown for this Rider in the Schedule.

**Outpatient** - We will pay benefits up to the benefit levels shown for this Rider in the Schedule. 30 visits may be exchanged on a 2-for-1 basis to secure up to 15 additional days under benefits provided for a **residential facility**.

This benefit is subject to the **deductible** and **coinsurance** provisions of the Policy. No additional benefits will be paid under any other Medical Expense Benefits of the policy

#### DEFINITIONS

**Substance Abuse** means abuse of or addiction to alcohol, drugs or chemicals.

**Residential Facility** means a facility that is properly licensed and operating under applicable state laws and regulations to provide inpatient services for **substance abuse**. It may be part of a **hospital**, or operating on its own. "Inpatient services" consist of 24-hour-a-day nursing services, supervision by a **doctor** and daily maintenance of patient records.

#### ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED

This rider is part of the policy and takes effect with respect to each **primary insured** on the Effective Date of the his **term of coverage**. This rider will cover a **primary insured's spouse** and any other **dependent** when properly enrolled and the required premium is paid. Complete the following if this coverage is issued after the Policy Effective Date.

## **ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE RIDER**

This Rider is attached to and made part of the **policy** as of the Effective Date. It is subject to all of the provisions, limitations and exclusions of the **policy** except as it is specifically modified by this Rider.

If the **participating institution** selects this coverage and pays the required additional premium, the following coverage will apply during your **term of coverage**:

**Death Benefit** - We will pay the Principal Sum shown below when your death occurs as a result of accidental **injury**. Loss of life must result within 90 days of the date of the accident causing such loss. Your coverage under the policy and this rider must be in force on the date of the accident and when loss of life occurs.

**Dismemberment Benefit** - If you sustain accidental **injury** that results in loss of limb or sight we will pay the portion of the Principal Sum shown below. Loss must occur within 90 days of the accident causing such loss. In the event of more than one loss only one sum will be paid.

For injury resulting in the loss of:

Life	\$10,000.00
Loss of two or more members	\$10,000.00
Loss of one member	\$5,000.00

"Member" means hand, arm, foot, leg or eye

"Loss of hand or foot" is severance at or above the wrist or ankle joint.

"Loss of sight" must be entire and irrecoverable.

The benefit amounts specific to this Rider are shown in the Schedule.

### **ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED**

This rider is part of the policy and takes effect for each **primary insured** on the Effective Date of his **term of coverage**.