LewerMark Student Insurance Programs
International Student Accident and Sickness Policy

underwritten by
Sirius International Insurance Corporation

UK Branch, 20 Fenchurch Street, 4th Floor
London EC3M 3BY, UK
(the "Company)

Policyholder:	**International Student Insurance Trust**
Policy Number:	**LM-193320-717**
Policy Term:	**August 15, 2019 through August 14, 2020**
State of Issue:	**Michigan**

The Company agrees to insure the eligible international students of each accepted Participating School against losses covered under this Accident and Sickness Policy (the "Policy") subject to its provisions, exceptions, and exclusions. The persons eligible to be insureds are those described in the Eligibility section of this Policy.

This insurance coverage is issued in consideration of timely payment of the required Premium and the statements set forth in the application for this Policy and each Participating School's application, each of which is attached to and made part of this Policy.

This coverage shall begin on the first day of the Coverage Term shown in the Participating School's application and on its Schedule of Benefits but will in no event begin prior to the first day of the Policy Term for this Policy. Coverage shall continue in effect until the last day of the Coverage Term so long as premiums are paid when due, unless the coverage is otherwise terminated as provided in this Policy. If the coverage is terminated, the insurance ends on the date to which Premiums have been paid.

Important notices regarding the Patient Protection and Affordable Care Act (PPACA)

This insurance is not subject to, and does not provide certain insurance benefits required by, PPACA. The insurance benefits are stated in this Policy and each Participating School's Schedule of Benefits.

PPACA requires U.S. citizens and certain U.S. residents to obtain PPACA-compliant insurance coverage unless they are otherwise exempt from PPACA. In certain circumstances, penalties may be imposed on U.S. citizens and residents who do not maintain PPACA compliant insurance coverage or who cease to qualify for exemption. Each Covered Person should consult a licensed, qualified attorney or tax professional to determine if PPACA's requirements applies to him or her.

This insurance is not a substitute for PPACA-compliant medical coverage. Lack of Minimum Essential Coverage may result in an additional payment with a Covered Person's taxes.

This Policy provides limited benefits and is not intended to cover all medical expenses.
Please read it carefully. This Policy is nonparticipating.

Program managed and administered by
The Lewer Agency, Inc.
4534 Wornall Road - Kansas City, MO 64111
800.821.7715
(the "Program Manager")

This insurance has been placed with an insurer that is not licensed by the state of Michigan. In case of insolvency, payment of claims may not be guaranteed.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions, and limitations applicable to its benefits, please read all the policy provisions carefully. Only those benefits elected by each Participating School and shown on its Schedule of Benefits will apply to its enrolled Eligible Students.

The Company has appointed the Program Manager to administer the Policy on its behalf. References to the Program Manager throughout this Policy are considered to include the Company where appropriate. Any notice delivered to the Program Manager shall be considered received by the Company.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read each benefit description section for full details.

Eligible Student: An Eligible Student is a registered and enrolled student of a Participating School who is all of the following:

1. a legal resident of a country other than the United States, its territories, or possessions;
2. is enrolled and actively engaged in Full-Time Studies;
3. has not been granted permanent residency status in the United States, its territories, or possessions; and
4. holds and continually maintains an F-1, J-1, M-1, Q-1 or other approved category of student visa or immigration status.

Visiting Faculty and Scholars

This section applies exclusively to individuals holding an Exchange Visitor non-immigrant visa, otherwise referred to as a J-1 visa.

J-1 visa holders who possess and maintain current passports and valid J-1 visa status may be considered for coverage under the Policy if engaged in educational activities with the Participating School.

J-1 visa holders will have access to all policy benefits and limits and will be subject to all exceptions and exclusions indicated herein. In addition, in compliance with Department of State requirements, insured J-1 visa holders who exhaust the stated Policy Year Maximum Benefit will have access to additional J-1 medical benefits of $100,000 per accident or illness. These additional J-1 medical benefits will be subject to all policy terms, internal benefit limits, exceptions, and exclusions.

Optional Practical Training

An eligible Optional Practical Training student with the applicable F-1 Visa may be considered eligible for coverage for a period of time no longer than twelve months from the date the student is approved for OPT while he or she is participating in Optional Practical Training work which is directly related to the major area of study. STEM OPT extension students are eligible for a maximum of twenty-four months coverage.

Optional Practical Training students who fail to maintain Optional Practical Training eligibility or who have transitioned to H-1B status will no longer be eligible for coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Applies only to Covered Students; terminates at age 65

Principal Sum	$10,000
Loss must occur within	90 days of the Covered Accident

Covered Student's Covered Loss	Accidental Death and Dismemberment Benefit
Life	100% of the Principal Sum
Quadriplegia (the total Paralysis* of both upper and lower limbs)	100% of the Principal Sum
Paraplegia (the total Paralysis* of both lower limbs)	50% of the Principal Sum
Hemiplegia (the total Paralysis* of upper and lower limbs on one side of the body)	50% of the Principal Sum
Two or more Members**	100% of the Principal Sum
One Member**	50% of the Principal Sum
Irrecoverable loss of sight of both eyes	100% of the Principal Sum
Irrecoverable loss of sight of one eye	50% of the Principal Sum
Irrecoverable loss of speech and hearing in both ears	100% of the Principal Sum
Irrecoverable loss of speech or hearing in both ears	50% of the Principal Sum
Thumb and index finger of same hand	25% of the Principal Sum

*__Paralysis__ means loss of use, without severance, of a limb. This loss must be determined by a Physician to be complete and not reversible.

**__Member__ means hand, foot, or eye (sight).

MEDICAL EXPENSE BENEFITS

The Policy provides different levels of benefits and copayments depending on where the Covered Person chooses to receive care or whether or not he or she uses the services of a Participating Provider. A Covered Person is free, however, to use the provider of his or her choice. The following benefits are available, per Covered Person, up to the amounts shown.

Policy Benefits – Per Covered Student	
Policy Year Maximum Benefit	$250,000
Annual Deductible - Applies to all Covered Benefits except to Prescription Drugs and Medical Treatment received at Student Health Centers	None
Policy Out-of-Pocket Expense Maximum	$3,000
Pre-Existing Condition Benefit – First six months of continuous coverage	$2,500

Copayments	
Student Health Center	$0
In-Network Provider	$20
Out-of-Network Provider	$35
In-Network Hospital	$50
Out-of-Network Hospital	$70
Hospital Emergency Room	$100 In-Network $100 Out-of-Network

Co-Insurance (applies to all Covered Benefits)	
In-Network Provider	100% of Allowed Charge
Out-of-Network Providers	80% of Reasonable and Customary expenses

When a Covered Person has satisfied the Policy Out-of-Pocket Expense Maximum during the policy year, all levels of Coinsurance will increase to 100% for any additional Covered Expenses incurred during the remainder of the policy year, and Copayment charges will no longer apply except as pertains to covered prescription drugs. Benefits will be paid at this level unless stated otherwise in the Covered Medical Expense section or in the Exceptions and Exclusions section. In addition, any benefit maximums will still apply and the Covered Person will not be reimbursed for any Copayments.

Satisfaction of the Policy Out-of-Pocket amount will not apply to outpatient prescription drugs expenses. Copayment and coinsurance will continue to apply to the Prescription Drugs Benefits received on an outpatient basis.

Prescription Drug Benefits	
Dispensed by a Student Health Center	100% of each 30-day supply
Dispensed by a Participating Network Pharmacy	70% of each 30-day supply
Dispensed while Inpatient at a Hospital	100%
Prescription Drug Benefit Maximum	$2,500
With respect to outpatient prescriptions, the Policy will pay the stated percentage for each 30-day supply.	

Payments toward the Prescription Drug Out-of-Pocket Expense Maximum will not count toward satisfying the Policy Out-of-Pocket Expense Maximum.

Contraceptives Benefits		
	At Student Health Centers and In-Network Providers	Out-of-Network
Prescription Contraceptives - Oral	100% of each 30-day supply	Not covered
Prescription Contraceptives – Non-Oral	50%	Not covered
There is no coverage for intrauterine devices (IUDs) or birth control implants and the procedures related to the placement and/or removal of such.		

Covered Benefits		
	In-Network	Out-of-Network
Hospital Room and Board at Semi-Private Room Rate	100%	80%
Intensive Care Unit (Average Charge)	100%	80%
Urgent Care	100%	80%
Outpatient Medical Care and Supplies	100%	80%
Pregnancy Benefits	100%	80%
Laboratory, X-Ray, and Diagnostic Examinations	100%	80%
Professional Ground Ambulance for Emergency Services	100%	100%
Professional Air Ambulance For Emergency Services	100%	100%
Infusion Therapy Benefit	100% up to a maximum of $10,000 per policy year	80% up to a maximum of $10,000 per policy year
Renal Dialysis/Hemodialysis Benefit	100% up to a maximum of $10,000 per policy year	80% up to a maximum of $10,000 per policy year
Medical Treatment of a Mental Condition	Inpatient – Aggregate maximum of 30 days per policy year Outpatient – Aggregate maximum of 30 visits per policy year	
Medical Treatment of Alcoholism or Drug Dependency	Inpatient – Aggregate maximum of 30 days per policy year Outpatient – Aggregate maximum of 30 visits per policy year	
Wellness Benefit Not subject to copayment	100% up to a Maximum Benefit of $250 per policy year	
Tuberculosis Testing Benefit	Included in the Wellness Benefit	
Immunization Benefit	Included in the Wellness Benefit	
Physiotherapy Benefit	Up to 20 visits per policy year A Copayment applies for each visit	
Acupuncture and Chiropractic Benefit	Up to $50 per visit after satisfaction of Copayment Maximum Benefit of $500 per policy year	
Home Country Coverage Benefit	Up to $1,500 per policy year	
Club/Intramural/Recreational Sports Benefit	100%	80%
Intercollegiate Sports Benefit Per Policy Year	$5,000	

Covered Benefits (continued)	
Aeronautics Benefit	Not covered
Self-Inflicted Injury Benefit	Not covered
Elective Abortion	Up to $1,000 per policy year
Dental Injury Benefit	Up to $2,500 per policy year
Palliative Treatment of Dental Pain Benefit	Not covered
Continuation Benefit	Available up to a maximum of 13 weeks or up to a Maximum Benefit of $10,000, whichever is reached first
Medical Evacuation Benefit	Up to $50,000 of Reasonable Expenses
Repatriation Benefit	Up to $25,000 of Reasonable Expenses

DEFINITIONS

Unless separately defined herein, wherever used in the Policy:

Acute Onset of a Pre-Existing Condition means a sudden and unexpected outbreak or recurrence of a Pre-Existing Condition which occurs spontaneously and without advance warning, which manifests itself in the form of symptoms or is indicated by a Physician, and for which immediate treatment is essential and necessary to stabilize the Pre-Existing Condition. See also Pre-Existing Condition.

Allowed Charge means the discounted fee that the provider Network negotiates with doctors, hospitals, and other health care providers in the Network.

Area means the location where the medical care or supplies are given within a region large enough to get a cross section of providers of medical care or supplies, as determined by the Program Manager.

Average Semiprivate Charge means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

Close Relative means the spouse, children, siblings, parents, and aunts and uncles of a Covered Person.

Club Sports means participation in sports as part of a club or team which may or may not be affiliated with the Participating School in which the athletes compete competitively with other similar clubs or teams.

Coinsurance means the percentage of a Covered Expense for which the Covered Person is responsible. Coinsurance is separate from and is not a part of the Copayment.

Congenital Condition means a disease or physical abnormality present at or before birth, regardless of cause.

Copayment means that portion of a Covered Expense a Covered Person is required to pay out of his or her pocket before benefits will be paid for any remaining portion. The Copayment is separate from and is not a part of the Coinsurance.

Covered Accident means an unexpected occurrence which is directly caused by external, visible means and which results in a Covered Injury to a Covered Person, and that occurs while coverage is in force for the Covered Person under this Policy.

Covered Dependent. When coverage for dependents is indicated on the Participating School's application and on the Schedule of Benefits, **Covered Dependent** means any dependent of a Covered Student who meets all of the following eligibility criteria:

1. is the Covered Student's lawful spouse, or unmarried child who is under age 19 and is a full-time student unless disabled;
2. resides with the Covered Student;
3. is enrolled for coverage under the Policy at the same time the Covered Student enrolls;
4. has a current passport and visa (non-domiciled United States Citizen – passport only); and
5. is temporarily outside his or her home country or country of regular domicile as a nonresident alien in the United States.

A dependent child includes a Covered Student's natural child; step-child; adopted child; or a child placed for adoption which means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. In cases where a Covered Student places a child for adoption, the child's association with the Covered Student is considered terminated upon the termination date of such legal obligation.

A Covered Student's dependent child who is born in the United States will be considered a dependent who may be considered eligible for coverage if Dependent coverage is indicated in the Educational Institution's application for coverage.

A Covered Student's disabled, unmarried dependent child may continue to be a Covered Dependent beyond age 19 if all of the following, additional conditions are met:

1. The child became disabled before reaching age 19;
2. The child is incapable of self-sustaining employment because of developmental disability or physical handicap and is chiefly dependent upon the Covered Student for support and maintenance;
3. The student remains insured under this Policy;
4. The child's premiums must be paid on time and in full;
5. Within 30 days of the child reaching age 19, the Covered Student furnishes a Statement of Disability to the Program Manager, the approval of such statement is required for the child to continue eligibility; and
6. The Covered Student provides satisfactory proof to the Program Manager of the child's disability and dependent status when requested. Such proof shall be without cost to the Company or the Program Manager. The Program Manager will not ask for proof more often than once a year after the two-year period following the child's attainment of age 19.

Covered Expense means only the expense actually incurred by a Covered Person for Medical Treatment which is Medically Necessary and which:

- is prescribed by a Physician for the therapeutic management of a Covered Injury or Covered Sickness;
- is not excluded by any provisions contained in the Policy; and
- is not more than the Reasonable and Customary charges, as defined by this Policy.

To determine if the amounts charged for Medical Treatments are Reasonable and Customary, the Program Manager will consider those Medical Treatments usually administered and the fees usually charged for a like Medical Treatment in the Area in which the service is rendered or the supply provided.

When the Covered Person utilizes the services of a Participating Provider, Covered Expense means the agreed upon rate set between the Program Manager and such provider for Medical Treatment which meet all of the above standards.

When the Covered Person utilizes the services of an Out-of-Network provider, the Covered Expense may be based on 200% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar services within the geographic market. In the event a Medicare-based amount is not available, the amount will be determined using a similar reference-based schedule as determined by the plan.

Covered Injury means bodily harm resulting, directly and independently of any sickness, and which is caused by, arises out of, or results from a Covered Accident or the sudden onset of physical trauma to that Covered Person. All injuries sustained in any one Covered Accident, including all related conditions and recurring symptoms, will be considered as one Covered Injury.

Covered Person means a Covered Student and any of his or her Covered Dependents if and only if coverage for dependents is included in the Participating School's application for coverage as approved by the Program Manager.

Covered Sickness means an illness, disease, or condition that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an injury or accident. All related disorders and recurrent symptoms of the same or a similar illness, disease, or condition will be considered the same Covered Sickness. A Covered Sickness includes pregnancy when conception occurred while the Covered Person was insured under this Policy.

Covered Student means an Eligible Student, as defined in the Schedule of Benefits, of a Participating School which has submitted an application for coverage which has been accepted by the Program Manager, and for whom premium has been paid when due.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Student, whether or not totally disabled, in the activities of daily living.

Deductible means the amount that the Covered Person must pay out-of-pocket before benefits may be payable under the Policy.

Full-Time Studies means the enrollment and active participation in at least the minimum number of credit hours in which an international student must be enrolled and actively attending classes in the United States per the terms of the applicable student visa. Full-Time Studies includes participation in no more than one online or television course per term; any online or television coursework in excess of one course per term does not count toward fulfilling the full-time status requirement for eligibility. Home study and correspondence courses do not count toward fulfilling the full-time status requirement for eligibility.

Emergency Medical Condition means a Covered Injury or Covered Sickness that manifests itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual, or in the case of a pregnant woman, the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services means covered inpatient and outpatient Medical Treatment that is furnished by a provider who is qualified to furnish the services, and that is needed to evaluate or stabilize an Emergency Medical Condition. Reimbursement for Emergency Services shall not be denied solely on the grounds that services were performed by a noncontracted provider.

Experimental means a Medical Treatment that has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further clarity, a Medical Treatment is Experimental:

- if the drug or device cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; except where the drug is recognized for treatment of a particular cancer in at least one standard reference compendia or the drug is recommended for that particular type of cancer based on substantially accepted peer-reviewed medical literature;
- if reliable evidence shows that the Medical Treatment is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts regarding the Medical Treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols by the treating facility or the protocols of another facility studying substantially the same Medical Treatment; or the written informed consent used by the treating facility or by another facility studying substantially the same Medical Treatment.

Hospital means only such a facility that meets all of the following conditions:

- operates as a Hospital pursuant to law for the care and treatment of sick or injured individuals;
- has permanent and full-time care for bed patients;
- has a staff of one or more licensed Physicians available at all times;
- provides 24-hour a day care by Registered Nurses on duty or call;
- has surgical facilities; and
- is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a Hospital used as such.

Hospital can also refer to a free standing surgical center that meets all of the following standards:

- is a licensed public or private place;
- has an organized medical staff of Physicians;
- has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care; and
- has Registered Nurse services when a patient is in the facility.

Intensive Care Unit means a specifically designated unit of a Hospital exclusively reserved for critically ill or injured patients requiring constant audio-visual observation, as prescribed by the attending Physician, which provides room and board,

trained and qualified personnel whose duties are primarily confined to such unit, and special equipment or supplies immediately available on a stand-by basis, and segregated from the rest of the Hospital's facilities.

Intercollegiate Sports means participation in a sports program or competition (including but not limited to involvement in any game, match, exhibition, scrimmage, practice, sanctioned training activity, joint practice, or tryout) in which the athletes compete competitively with other universities or colleges and which may or may not be regulated by a collegiate athletic association.

Intramural Sports means participation in sports organized and played within a university or college or within a local, formalized league.

Medical Treatment means any and all medical care, treatment, services, supplies, procedures, or drugs that may be administered to a Covered Person to address a sickness or injury.

Medically Necessary means those Medical Treatments, provided or prescribed by a Physician or at a Hospital, that are necessary and appropriate for the diagnosis or management of a Covered Sickness or Covered Injury in accordance with generally accepted standards of medical practice in the United States at the time the Medical Treatment is provided. When specifically applied to a confinement, Medically Necessary means that the diagnosis or management of the symptoms or condition cannot be safely provided on an outpatient basis.

A Medical Treatment shall not be considered as Medically Necessary if it:

- is Experimental, investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient's family, Physician, Hospital, or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration except as permitted by regulations drafted in accordance with applicable federal law; or
- involves Medical Treatment not considered reasonable and necessary by the Centers for Medicare and Medicaid National Coverage Determinations Manual.

We retain the right to determine whether a Medical Treatment is Medically Necessary.

Mental Condition means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder.

Network means a compilation of health care providers, such as Physicians and Hospitals, that have agreed to accept reduced payments for Medical Treatment received by the Covered Person. The Covered Person has discretion to visit any health care provider, regardless whether that provider is included in the Network (In-Network) or does not participate in the Network (Out-of-Network). Regardless whether the Covered Person elects to utilize an In-Network or Out-of-Network health care provider, he or she may still incur out-of-pocket expenses.

Participating Provider means a health care provider, such as a Physician or a Hospital, that is included in the Network and has agreed to provide Medically Necessary Medical Treatment at set rates.

Participating School means the educational institution that has elected to offer coverage to its Eligible Students under this Policy through submission of a completed application for coverage which includes participation in the Trust, which has been accepted by the Program Manager, and for which coverage has become effective and has not terminated.

Physician means a legally licensed practitioner of the healing arts who is practicing within the scope of his or her physician's license while performing a particular service which is covered under the Policy. For the sake of clarity, Physician includes Nurse Practitioners. Physician does not include:

- a practitioner of chiropractic, naturopathic, naprapathic, or alternative medicine;
- any Covered Person;
- a Close Relative of a Covered Person; or
- an individual residing at the same legal residence of the Covered Person.

Physiotherapy means the Medical Treatment of a Covered Sickness or Covered Injury by the use of physical means including, but not limited to, air, heat, light, water, electricity, or active exercise.

Policyholder means the entity to which the Policy is issued. The Policyholder is shown on the first page of the Policy.

Pre-Existing Condition means either or both of the following:

- an injury or sickness about which the Covered Person
    - has consulted a Physician;
    - had medicine prescribed; or
    - is receiving or has received medical care

  during the six-month period immediately preceding the Covered Person's Effective Date of Coverage under the Policy; or
- a pregnancy which originated prior to the Covered Person's Effective Date of Coverage under the Policy.

See also **Acute Onset of a Pre-Existing Condition**.

Reasonable and Customary means the most common charge for similar Medical Treatment within the Area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate, if any; and
- The fee often charged in the Area where the service was performed.
- Up to 200% of the Medicare published rate for the same or similar service.

Recreational Sports means competitive physical activities that are played primarily for fun or as a past time.

Registered Nurse or Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other similar state authority. Registered Nurse does not include:

- any Covered Person;
- a Close Relative of a Covered Person; or
- an individual residing at the same legal residence of the Covered Person.

Sound Natural Teeth means teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

Student Health Center means an ambulatory care facility affiliated or contracted with a Participating School that, at a minimum, maintains a staff consisting of a nurse director/nurse practitioner, staff Nurses, and either a staff Physician or an arrangement with a Physician to perform office visits. In the event a Participating School does not otherwise have a Student Health Center, the Participating School may request permission from the Program Manager to designate a Walk-In Pharmacy Clinic to be treated as a Student Health Center for the purposes of this Policy.

Walk-In Pharmacy Clinic means a clinic which is set-up inside a larger retail operation, such as a pharmacy or retail store, and which provides basic care for minor injuries and illnesses, and may provide vaccinations, immunizations, annual physicals, health screenings, and diagnostic tests.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION, AND EXTENDED COVERAGE PROVISIONS

Policy Effective Date
The Company agrees to provide the insurance benefits described in this Policy in consideration for the Policyholder's application and the payment of all premiums when due. The Policy will become effective on the first day of the Policy Term shown in the Policy's Schedule of Benefits.

Participating School's Coverage Effective Date
The insurance coverage becomes effective for the Participating School on the later of the first day of the Policy Term or the date requested on the Participating School's application and shown on the Participating School Schedule of Benefits, subject to payment of premiums due.

Eligibility
A student of the Participating School is eligible for insurance under this Policy when he or she meets the definition of an Eligible Student shown in the Schedule of Benefits.

Effective Date for Eligible Students
Provided we have received the required premium, coverage for a Participating School's Eligible Students will become effective:

1. on the first day of the school term for which coverage is applied if the individual became an Eligible Student on the first day of the school term and applied within the first 30 days of the school term;
2. on the first day the individual became an Eligible Student if such day is after the first day of the school term, and enrollment was made within 30 days of becoming an Eligible Student;
3. on the first day an Eligible Student suffered an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment was made within 30 days of such loss of coverage;
4. on the first day of the next school term if enrollment was requested more than 30 days after becoming an Eligible Student or after an Eligible Student suffers an involuntary loss of other coverage; or
5. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

Coverage will not become effective for a student if the student is not actively engaged in Full-Time Studies for at least the first 31 days of each school term, unless the student is unable to attend class due to an acute sickness or injury.

The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met and authorizes the Program Manager to do so on its behalf. If and whenever the Program Manager discovers that the Policy eligibility requirements have not been met and no claims have been paid, the Company's only obligation is to refund premium. No refund will be made if the individual has filed a claim against the coverage during the then-current term.

Effective Date for Dependents
If dependent coverage has been included on the Participating School's application and approved by the Program Manager, and provided Premium has been received by the Program Manager in accordance with the Policy provisions, the Effective Date of Coverage for the Covered Dependent of a Covered Student will be determined in the following order:

1. the date the Covered Student's coverage begins;
2. the date of Child's birth, adoption, or placement for adoption, if enrollment was made within 30 days of such event;
3. on the first day of the first month following the dependent's initial eligibility date for dependents joining a Covered Student's family through marriage or other court decree while the Insured Student was covered under the Policy;
4. on the first day of the first month following the date the dependent first meets the definition of an "Eligible Dependent" if such dependent did not qualify at the time the Insured Student was enrolled under the Policy, and enrollment is made within 30 days of such loss;
5. on the first day an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 30 days of such loss;
6. on the first day of the next school term if enrollment is made more than 30 days after becoming an Eligible Dependent or after an Eligible Dependent suffers an involuntary loss of other coverage; or
7. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

Coverage for a dependent cannot become effective prior to the Effective Date of Coverage for the Covered Student.

See the Extended Coverage Benefit for additional information.

Newborn Infants - Sick Baby Care: A newborn child of a Covered Person will automatically be considered a Covered Dependent for 30 days from the moment of birth **only** for Covered Expenses incurred which are due directly to a Covered Injury or Covered Sickness, premature birth, or birth abnormalities which exist at birth up to a maximum benefit of $50,000.

Newborn Infants - Well Baby Care: A newborn child of a Covered Person will automatically be considered a Covered Dependent from the moment of birth if: (1) notice of the birth of the child is provided to the Program Manager within 30 days from the date of the birth, and (2) the Program Manager must have received the required premium. Covered Expenses for the newborn child will include: (a) Hospital room and board (or nursery) charges, (b) routine Physician visits while Hospital confined; and (c) circumcision while Hospital confined. Such Covered Expenses for Well Baby Care are payable until the earlier of the date the child is discharged from the Hospital or the date the child is 7 days old.

In order to continue the coverage beyond the 31st day following date of the child's birth: (1) the institution's plan must include coverage for Eligible Dependents, (2) notice of the birth of the child must be provided to the Program Manager within 60 days from the date of the child's birth, and (3) the Program Manager must have received the required premium. If any of (1), (2), and (3) above are not satisfied, the coverage for the newborn child, including any Continuation of Benefits, will terminate 60 days from the date of birth.

Termination of Coverage

Insurance under this Policy will automatically terminate for a Covered Person on the earliest of the following dates:

1. the date the Participating School's coverage under the Policy terminates;
2. the last day of the period for which premium has been timely paid according to Policy provisions (refer to the Premium provision);
3. the date the Covered Person is no longer eligible for coverage;
4. the date requested by the Covered Person and approved by the Participating School in writing that is no sooner than 5 days after the date the Program Manager receives written notice. Any unearned premium will be returned, but returned premium will only be for the number of full months remaining in the unexpired term of coverage;
5. the date the Covered Person departs the United States for his or her home country or country of regular domicile; or
6. the date the Medical Benefit Maximum applicable to the Covered Person has been exhausted.

See the Extended Coverage Benefit section for additional information.

Extended Coverage

Benefits under this Policy are available beginning on the Effective Date and ending upon the Expiration Date, as indicated on page 1.

However, an Extended Coverage Benefit can provide up to 30 days of additional coverage to certain students of the Participating Organization, specifically to:

1. newly-enrolled students prior to the beginning of their very first terms of study with the Participating Organization, or
2. Covered Students who have completed their final terms of study in the United States and are preparing to return to their home countries.

For Newly-Enrolled Students

To be eligible for the Extended Coverage Benefit and before any benefits will be paid:

1. a newly-enrolled student must have enrolled in Full-Time Studies at the Participating School, and
2. the Participating School must have remitted all premiums to the Program Manager.

Coverage under the Extended Coverage Benefit will become effective on the later of:

1. up to 30 days prior to the beginning of the term, or
2. for arriving students, the date the qualifying, newly-enrolled, and arriving student arrives in the United States prior to classes, or
3. for transfer students, the termination date of the student's prior insurance coverage through the previous educational institution.

For Covered Students Concluding their Studies

To be eligible for the Extended Coverage Benefit and before any benefits will be paid:

1. the Program Manager must receive the request for Extended Coverage prior to the Termination Date of the Covered Student's coverage as defined in the Termination of Coverage Section, and
2. all premiums must be paid.

Coverage under the Extended Coverage Benefit will terminate on the earlier of:

1. 30 days following the Covered Student's graduation or completion of an educational program, or
2. the date he or she departs the United States.

Important Information about the Extended Coverage Benefit

This Extended Coverage Benefit is subject to all other applicable policy terms, conditions, exclusions, and limits, including any applicable pre-existing condition limitation.

Extended Coverage for Short-Term Programs

In the event the Eligible Student's entire program of study is less than 60 days, the applicable Extended Coverage Benefit will be limited to seven days. All other Extended Coverage Benefit provisions will apply as indicated herein.

GENERAL PROVISIONS

Entire Contract
This Policy, the Policyholder's application, a Participating School's application, and the Schedule of Benefits, along with any endorsements, amendments, riders and any attached papers shall constitute the Entire Contract between the parties.

Evidence of Coverage
A Schedule of Benefits, a copy of the Participating School's application, and a copy of this Policy will be issued to each Participating School. The Schedule of Benefits will show the benefits elected by the Participating School and available to Covered Persons. The Participating School must have this Policy available for inspection by Covered Persons at all reasonable times.

Covered Persons may receive a brochure which outlines the benefits of the coverage. The brochure shall serve as an outline and evidence of the insurance coverage provided by this Policy and the Participating School's Schedule of Benefits, but does not extend or change that insurance coverage.

In the event of any conflict between any brochure, the Participating School's Schedule of Benefits, and this Policy, the terms of the Policy will govern.

Policy Changes
The Program Manager may amend or change this Policy at any time by giving advance written notice to the Policyholder and the Participating School. No change to this Policy may be made or will be considered valid until approved by an executive officer of the Program Manager. In order to be valid, the approval must be in writing, and must either be endorsed on or attached to this Policy. No agent or broker has any authority to alter this Policy or waive any of its provisions.

Incontestability of this Policy
All statements made by the Policyholder or Participating School to obtain the Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of the coverage under the Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Participating School.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

Incontestability of the Covered Person's Insurance
All statements made by any Covered Person are considered representations and not warranties. No statement will be used 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 the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

Premiums
Coverage for each Participating School shall begin on the Effective Date shown in its Schedule of Benefits, and shall continue in effect until the Termination Date so long as Premiums are paid in full when due. No claims can be paid until the Program Manager receives the full Premium for all Covered Persons.

Full Premium for the term is considered due on the Participating School's Effective Date of the coverage and future Premiums are considered due for each school term on the first day of the term. For each period of coverage, the Participating School shall submit to the Program Manager a roster of, and premiums for, all Covered Persons.

Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided in the Grace Period provision. Failure to pay premiums when due or within the Grace Period shall be deemed as notice to terminate coverage at the end of the period for which premium was paid.

Grace Period
If the full Premium is not paid within 60 days after the due date, the Participating School shall have a 30-day Grace Period in which to pay the full Premium.

However, if the Premium is not paid by the end of the Grace Period, the Participating School's coverage under this Policy will cease to be in effect, coverage will terminate retroactively to the last date for which Premium was paid, and no expenses incurred during the Grace Period will be considered for payment.

If the Participating School has sent notice of its intent to terminate coverage, the Grace Period section shall not apply.

Reinstatement
If coverage is terminated for failure to pay Premium, the Participating School may apply for Reinstatement of coverage by submitting an application within 90 days from the date coverage ended.

Any application for reinstatement will not become effective unless and until the Program Manager approves such application and all Premiums have been paid in full. The Program Manager will advise the Participating School of the Effective Date of Reinstatement by issuing a new Schedule of Benefits. Any reinstated coverage will provide benefits for only:

- Covered Injuries occurring after the Effective Date of Reinstatement; and
- Covered Sicknesses that begin more than ten days after the Effective Date of Reinstatement.

The reinstated coverage will be subject to the Incontestability provision from the Effective Date of the Reinstatement.

In all other respects, all rights under the Policy will remain the same, subject to any new conditions imposed as a result of the Reinstatement.

If the Participating School has sent us notice of its intent to terminate coverage, the Reinstatement section shall not apply.

Changes in Premium Rates
We have the right to change the premium rates on any Participating School's premium due date but will not do so any more often than once in any six-month period, except for rate changes required due to changes in premium tax law.

Premium payments made in advance, or for more than a one-month period, will not affect any rights we have with regard to premium changes.

Notwithstanding anything in this Policy to the contrary, the Program Manager may change the premium rate on any date:

- this Policy is amended;
- there is a change in the coverage provided or classes eligible; or
- there is a change in the risks we have assumed.

We will give 30 days' written notice of any change. Notice will be sent to the Policyholder and to the Participating School at the most recent address in our records.

Clerical Error
Any clerical error made by the Company or the Program Manager shall not invalidate coverage otherwise in force, or make the coverage of an ineligible person valid, or continue coverage that was ended by valid means. Neither the passage of time nor the payment of premiums for a person who is not eligible for coverage under the terms of the Policy will make this coverage valid for such person. If it is found that such a person was included when the premium was figured for the Policy, the only liability shall be the proper refund of premiums. In addition, when a person is no longer eligible for coverage under the Policy, the payment of premiums for such person shall not continue coverage past the date such person ceases to be eligible. Again, the only liability shall be the proper refund of premiums.

Any such clerical errors must be corrected and promptly reported to the Program Manager. The Program Manager maintains the right to recover from you any overpayment of benefits due to such clerical errors.

Waiver
Waiver of any provision of this Policy by the Company or the Program Manager shall not affect its right to enforce the provision at any time thereafter against any person or entity claiming rights under the Policy.

Termination of Coverage by a Participating School
A Participating School may cancel its coverage under this Policy by providing written notice to the Program Manager at its office. Once coverage has been issued, the coverage will remain in effect until the later of:

1. the date the Program Manager receives such notice; or
2. the date set by such notice;

subject to the coverage ending prior to this notice because of expiration of the Grace Period.

If premiums are not paid, this coverage shall end as stated in the Grace Period section of this Policy.

Termination of Coverage by the Company
The Company or the Program Manager may refuse to continue in force the coverage under this Policy for a Participating School by providing written notice to it at least 30 days prior to the date of termination:

1. in the event of fraud or intentional misrepresentation of a material fact by the Participating School; or
2. if the Participating School fails to meet minimum participation requirements; or
3. with respect to a provider network, if there is no longer any Covered Person who lives or attends school in the Area.

Coverage may be terminated prospectively at any time for fraud or misrepresentation without 30 days prior notice. Coverage may be rescinded back to the Effective Date for fraud or intentional misrepresentation of material fact with at least 30 days' prior written notice.

The Company may end Accidental Death and Dismemberment coverage, if any, by giving notice in writing to the Participating School at least 30 days prior to the date it is to be canceled.

The Company or the Program Manager may terminate this coverage by giving notice, in writing, to a Participating School at least 30 days prior to the date the insurance will end in the event the Participating School fails to meet either of the following minimum participation requirements:

1. the number of Covered Students is fewer than 10 during any given semester, trimester, or quarter; or
2. fewer than 100% of those Eligible Students who do not already have medical or health care coverage from other sources are insured under this Policy.

Legal Actions
No action at law or in equity may be brought to recover on this Policy before the end of 60 days and after proof in writing of the loss has been given, as required by the Policy. No such action may be brought after three years from the time written proof of loss is required to be given.

CLAIMS PROVISIONS

Notice and Proof of Claim - Timely Filing Requirement
Written proof of loss must be given to the Program Manager within 90 days after the date of loss or as soon as thereafter as reasonably possible. Notice should include the name of the Covered Person, the Participating School's identifying number, and the Covered Person's contact information including, address, email address, and any other necessary information that may be reasonably required. If services are rendered on consecutive days, such as for a hospital confinement, the date of loss will be considered the last date of service. The Program Manager will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Program Manager within one one-year after the date of service. If a claim was timely filed originally, but the plan's Program Manager requested additional documentation, the healthcare provider has up one-year to submit the requested information.

Claims Questionnaire
After receiving notice of claim, the Program Manager will send a Claims Questionnaire to the Covered Student. If the Covered Student does not receive this document within 15 days after providing written notice, he or she can meet proof of claim requirements by submitting to the Program Manager a written statement of the nature and extent of the loss within 90 days after the date of loss or as soon thereafter as reasonably possible.

This proper positive written notice and proof of loss must be provided before the Company will be liable for any loss or benefits. Failure to furnish written proof of loss within that time frame will neither invalidate nor reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than one year from the date of the loss, except in the absence of legal capacity.

Submission of Supporting Medical Documents
When claims received from healthcare providers require additional documentation to determine medical necessity, pre-existing condition and/or determine the cause of an injury, the healthcare provider has a one-year submission widow to make the documentation available to the Program Manager. If medical records are received outside of this one-year submission window, any claims denied and pending receipt of supporting medical records will remain denied, and will no longer be eligible for review. If the medical records are received within one year of the request date, the records will be used to adjudicate the claim.

Claim Payments
Benefits will be paid as soon as the Program Manager receives satisfactory proof of loss. All benefits other than for accidental loss of life will be paid to the Covered Student subject to any written assignment of benefits which is authorized by this Policy and made on a form satisfactory to the Program Manager.

Assignments and Claims of Creditors
The Covered Person may assign the benefits payable under this Policy only to such person or institution rendering services or furnishing supplies for which benefits are payable. Neither the Company nor the Program Manager shall be responsible for the validity of any such assignment. Any payment made according to such assignment and in good faith by the Program Manager will discharge the Company and the Program Manager to the extent of any such payment.

To the extent permitted by law, neither the benefits nor payments under this Policy will be subject to the claims of creditors or to any legal process by any creditor of the Covered Person or Beneficiary.

Physical Examinations and Autopsy
The Company, at its own expense, shall have the right to examine a Covered Person with respect to whom benefits are claimed as often as reasonably needed while the claim is pending. The Company reserves the right to have an autopsy performed at its expense, unless prohibited by law.

Misstatement of Age
If the age of any Covered Person has been misstated, any amounts payable will be the amounts the premium would have purchased or the benefits that would have been available at the correct age. Any such misstatement shall neither continue insurance ended by valid means nor void insurance otherwise valid and in force.

Premium adjustments, including collection of any premium due because of past underpayments, will be made so that the proper Premiums are received for the Covered Person's correct age.

If an individual would not have been eligible for coverage at the correct age on the Participating School's Effective Date of Coverage, the individual's coverage will be voided as of the date we determine the correct age and return any premiums paid, minus any claims that have been paid on the individual's behalf.

Right of Reimbursement
The Company shall have a lien against any recovery received by a Covered Person as compensation for a Covered Injury or Covered Sickness to the extent that the Covered Person received benefits for such Covered Injury or Covered Sickness under this Policy. Thus, if a Covered Person recovers expenses for a Covered Sickness or a Covered Injury that occurred due to the negligence of a third party, the Company has the right to first reimbursement for all benefits 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, by his or her parents if the Covered Person is a minor, or by the legal representative. The Covered Person is required to furnish any information or assistance, or provide any documents that the Company or the Program Manager may reasonably require in order to exercise the Company's rights under this provision. This provision applies whether or not the third party admits liability.

Sanction Limitation and Exclusion Clause
No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America. LMA3100

COORDINATION OF BENEFITS

Some people have health care coverage through more than one medical insurance plan at the same time. The Coordination of Benefits provision allows these plans to work together so the total amount of all benefits paid by all Plans will never exceed 100 percent of the Allowable Expenses during any coverage year. This helps to hold down the costs of your health coverage. The Coordination of Benefits provision will apply when an individual has health care coverage/benefits available under more than one Plan.

Coordination of Benefits
If Covered Person is also covered under one or more other Plans, the benefits payable under this Policy will be coordinated with the benefits payable under all other Plans so that the combined benefits paid or provided by all coverages will not exceed 100% of the Allowable Expenses incurred during any Claim Determination Period.

The Covered Person must inform the Program Manager if he has other coverage (for example, through a spouse's or parent's employer) and give consent to the release of information so that this provision may be used. The Covered Person should first file the claim with the primary plan (as defined below). When the claim is paid, the Covered Person should send a copy of the charges and a copy of the Explanation of Benefits Statement from the first plan to the secondary plan (as defined below, which will accelerate the processing of a claim.

Benefit Determination Rules
One Plan will be determined to be primary (using the rules below). The primary plan pays its full benefits first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits. A plan is primary when:

1. the plan does not have a Coordination of Benefits provision; or
2. if both plans have a Coordination of Benefits provision, under the rules it is determined to be primary.

When both plans have a Coordination of Benefits provision, the order in which the plans provide benefits is determined using the first of the following rules which applies:

1. Covered Student. The plan which covers the individual as a Covered Student is primary. If Covered Student is also covered by Medicare, the plan covering the individual as a Covered Student is primary, the plan covering the individual as a dependent of a Covered Student is secondary, and Medicare is third.
2. Continuation Coverage. Continuation coverage provided under either federal or state law is secondary.
3. Length of Coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the individual for the longest period of time will be considered primary. If none of the preceding requirements determines the primary plan, the allowable expenses will be shared equally between the plans.

If this Plan is determined to be secondary, benefits payable under this Policy will be reduced so that the total benefits provided by all plans during a Claim Determination Period are not more than the total Allowable Expenses for the Covered Person. The Program Manager will use the amount by which benefits have been reduced to pay Allowable Expenses not otherwise paid, which were incurred during the Claim Determination Period and have been submitted for that Covered Person.

The actual benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Policy will never exceed the amount that would have been paid if there were no other plans involved. If benefit payments under this Policy are reduced by Coordination of Benefits, only the reduced amounts will be charged against the Covered Person's plan maximums.

If during Coordination of Benefits, payments are made in error, the plans will have the right to adjust payments among themselves. Such payments satisfy the Company's liability. If a claim is overpaid under this Policy, the Company has the right to recover such overpayments from any individual for, to whom, or with respect to whom such payments were made, any other insurance company, or any other organization.

As used in the Coordination of Benefits Section, the following definitions shall apply:

An **Allowable Expense,** means any necessary, usual, Reasonable and Customary item of expense, at least a part of which is covered by any one of the Plans that covers the individual for whom claim is made. When benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Claim Determination Period means a coverage year or that part of a coverage year in which the individual has been covered under the relevant coverage.

Plan, as used in the Coordination of Benefits provision, is any of the following which provides health benefits or services:

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;
3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. medical benefits provided by any governmental plan or coverage or other benefit law, except:
    a. a state-sponsored Medicaid plan; or
    b. a plan or law providing benefits only in excess of any private or non-governmental plan;
6. single or family subscribed plans issued under a group or blanket type plan;
7. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
8. individual health benefit plan; but the definition of plan shall not include:
    a. hospital indemnity type plans;
    b. school accident-type coverage.

Coordination of Benefits does not apply to the accidental death and dismemberment benefits.

Service of Legal Process

Subject to and without limiting, expanding, superseding, modifying or waiving any of the foregoing terms contained in this Section, pursuant to any statute of any State, territory or district of the United States which makes provision thereof, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance (or such other officer specified for that purpose in the statute), or his successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of a Covered Person arising out of this insurance. Such process may be submitted specifically to the **Commissioner of Insurance for the Michigan Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933**, or the Superintendent, Commissioner, or Director of Insurance of the state in which the Covered Person resides. Further, the Company hereby designates and appoints John P. Dearie, Jr., Esq., Edwards & Angell, LLP, 750 Lexington Avenue, New York, New York 10022, as its attorney-in-fact and agent for service of process to whom the said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS *Not applicable to any insured dependents*

Covered Losses

The Company will pay the Accidental Death and Dismemberment Benefit for any one of the Covered Losses listed in the **Schedule of Benefits** if the Covered Student suffers a Covered Loss as the direct result of a Covered Accident, subject to the Exceptions and Exclusions indicated in the Policy. The Company will only pay the Accidental Death and Dismemberment Benefit after the Program Manager receives written proof of such loss. The loss must be incurred within 90 days of the Covered Accident.

If the Covered Student sustains more than one Covered Loss as a result of the same Covered Accident, the Company will pay only the Benefit for the Covered Loss for which the largest benefit is payable. Payment will be made to the Covered Student. Benefits for accidental loss of life will be paid to the Covered Student's Beneficiary. Unless the Insured Student indicates otherwise, the Company will pay the benefit for accidental loss of life in this order to:

1. the Covered Student's spouse, if living;
2. the Covered Student's Children, in equal shares, if living;
3. the Covered Student's parents, in equal shares, or to the surviving parent, if living;
4. the Covered Student's brothers or sisters, in equal shares, if living;
5. the Covered Student's estate (if no Beneficiary survives the Covered Student).

The Covered Student can name or change the Beneficiary at any time by sending written notice to the Program Manager. If the Covered Student names more than one Beneficiary, the Program Manager will pay the Benefit in equal shares unless the Covered Student indicates otherwise. If the Program Manager pays the Benefit before receiving the notice of a change in Beneficiary, neither the Company nor the Program Manager will pay the Benefit again.

COVERED MEDICAL EXPENSES

The Company will pay benefits subject to the exclusions, limitations, and all other provisions of this Policy, for a Covered Expense if:

1. the Copayment or Deductible, if any, is met;
2. the expense is incurred due to a Covered Injury or Covered Sickness;
3. the Covered Person has not exceeded the Policy's benefit maximums.

The Company will consider each Covered Expense to be incurred on the date the medical care or supply is received. Pursuant to determining eligibility for benefits and subject to the limits shown in the Schedule of Benefits, the Policy will pay benefits for the following Covered Expenses:

1. For the diagnosis and Medical Treatment by a Physician or a Registered Nurse.

2. For daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges.

3. For charges by a Hospital for outpatient medical care received on an outpatient basis and medical supplies which are used on the premises of a Hospital.

4. For home health care services which are performed by a licensed home health care agency, which have been prescribed by a Physician, and which are performed in lieu of Hospital services, provided the Hospital services would have been Covered Expenses under the Policy.

5. For laboratory, x-ray, diagnostic imaging, and other diagnostic examinations.

6. **Prescription Drugs.** For prescription drugs as shown in the Schedule of Benefits.

7. **Urgent Care.** For care received in an urgent care center or facility.

8. **Emergency Ambulance Service.** For professional ambulance assistance for Emergency Services or required in connection with an Emergency Medical Condition by ground or by air to a Hospital. (See Medical Evacuation Benefit for air service to a Covered Person's home country.)

9. **Orthopedic Devices, Prosthetic Devices, or Hospital Equipment.** For the following types of prescribed orthopedic or prosthetic devices or Hospital equipment:

- **a.** man-made limbs or eyes for the replacing of natural limbs or eyes;
- **b.** casts, splints, or crutches;
- **c.** purchase of a truss or brace;
- **d.** oxygen and rental of equipment for giving oxygen;
- **e.** rental cost, up to the purchase price, of a standard wheelchair or Hospital bed;
- **f.** rental of dialysis equipment and supplies;
- **g.** colostomy bags and ureterostomy bags; and
- **h.** two external post-operative breast prostheses.

The Policy does not provide benefits for rental charges for equipment in excess of the purchase price of the equipment.

10. **Mental Conditions.** For the Medical Treatment of a mental condition either in an inpatient facility, or on an outpatient basis in either an individual or group setting.

11. **Alcoholism or Drug Dependency.** For Medical Treatment of alcoholism or drug dependency either in an inpatient facility, or on an outpatient basis in either an individual or group setting.

12. **Wellness Benefit.** For any combination of the following: routine physical or health examinations, sports physicals, gynecologic health screenings, routine baseline or screening mammograms, prostate and/or colorectal examinations and related laboratory tests, annual health checkups, immunizations indicated on the Recommended Immunization Schedule by the Centers for Disease Control and Prevention, and tuberculosis tests.

13. **Physiotherapy, Acupuncture, and Chiropractic Benefits.** For Physiotherapy, Acupuncture, and Chiropractic services which are prescribed by a Physician, which are incurred while not confined in a Hospital, and which are billed by a Physician, chiropractor, or physiotherapist. Charges for in excess of the maximums set forth in the Schedule of Benefits shall not be included as Covered Expenses under the Policy.

14. **Pregnancy Benefits.** For pregnancy coverage including prenatal visits, two ultrasounds per pregnancy (unless more are Medically Necessary), and post-delivery inpatient Hospital care for a mother in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists which is 48 hours following a vaginal delivery, or 96 hours following a caesarean section. A decision to shorten the length of stay may be made by the attending Physician in consultation with the mother.

    In order to be considered eligible for Pregnancy Benefits, conception must have occurred following the Effective Date of the Covered Person's coverage. If the Covered Person is eligible for Pregnancy Benefits, benefits will be payable on the same basis as Covered Expenses for any other Covered Sickness.

    This Policy does not provide coverage for care services provided by birth doulas, companions, or birth supporters who assist a woman before, during and/or after childbirth, or for planned childbirth deliveries at home.

15. **Post-Mastectomy Coverage.** For charges for a Medically Necessary mastectomy which may also include coverage of the following:
    - **a.** physical complications during any stage of the mastectomy, including lymphedemas;
    - **b.** reconstruction of the breast;
    - **c.** surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
    - **d.** two external breast prostheses.

    Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

16. **Medical Evacuation Benefit:** Subject to prior approval from the Program Manager or its authorized representative, for reasonable expenses related to the air evacuation of an injured or sick Covered Person (and a Health Care Provider or Escort if such is directed by the attending Physician) to the Covered Person's home country or country of regular domicile, provided the air evacuation:
    - **a.** is upon the attending Physician's written certification;
    - **b.** results from a Covered Injury or Covered Sickness; and
    - **c. does not occur prior to the benefit approval.**

17. **Repatriation Benefit:** Subject to prior approval from the Program Manager or its authorized representative, for reasonable expenses incurred in connection with the preparation and transportation of the body of a deceased Covered Person to his or her place of residence in his or her home country. This benefit does not include transportation expenses of any person accompanying the body.

18. **Continuation Benefits:** For Covered Expenses incurred, while Hospital confined, as indicated in the Schedule of Benefits for a Covered Injury or Covered Sickness for which a Covered Person has a continuing claim on the date his or her coverage terminates. Benefits payable under this provision will terminate if a Covered Person becomes covered, for the Covered Injury or Covered Sickness for which benefits were continued, under any other medical coverage.

19. **Radiation Therapy and Chemotherapy:** Covered Expenses for radiation therapy, infusion therapy, and chemotherapy or for oral chemotherapy drugs which are prescribed and administered by a licensed Physician. Prior authorization is not required.

20. **Infusion Therapy:** Covered Expenses for infusion therapy for chronic conditions prescribed and administered by a licensed Physician. Infusion therapy required for cancer and cancer-related conditions will be considered under the Radiation Therapy and Chemotherapy provision.

21. **Renal Dialysis/Hemodialysis:** Covered Expenses for Renal Dialysis/Hemodialysis prescribed and administered by a Physician.

22. **Allergy Treatment:** Covered Expenses for Medically Necessary treatment of allergies, as diagnosed and prescribed by a Physician.

23. **Injectable and Provider-Administered Drugs:** Injectable drugs and other drugs administered in a Physician's office or other outpatient setting.

24. **Diabetes Coverage:** Covered Expenses for medical supplies, equipment and education for diabetes care for all diabetics.

25. **Skilled Nursing Facility:** Covered Expenses for items and services provided as an inpatient in a skilled nursing bed of skilled nursing facility or hospital, including room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other Medically Necessary services and supplies. Benefits are limited to 30 days per policy year. Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of hospice care.

26. **Dental Injury Benefit.** For charges related to the Medical Treatment of Sound Natural Teeth damaged as the result of a Covered Injury. This benefit does not cover damage to previously decayed teeth caused by chewing or biting.

27. **Home Country Coverage Benefit.** For Medical Treatment incurred in the Covered Student's Home Country related to a Covered Injury or Covered Sickness which occurred, was diagnosed and treated outside the Covered Student's Home Country during the period of coverage providing that the Covered Student remains on the Participating School's I-20, for a maximum of 90 days on an approved vacation term. Coverage will terminate when the individual permanently returns to his or her homeland or country of permanent residence.

28. **Club/Intramural/Recreational Sports Benefit.** For charges related to a Covered Injury arising out of practice for or participation in Club Sports, Intramural Sports, or Recreational Sports.

29. **Intercollegiate Sports Benefit.** For charges related to a Covered Injury arising out of practice for or participation in Intercollegiate Sports.

30. **Elective Abortion Benefit.** Covered Expenses related to the procedure for an elective abortion, provided that conception occurred after the Effective Date of the insured's coverage under the Policy. If the insured experiences complications from the procedure, the Covered Expenses will be assessed the same as any other Covered Benefit.

EXCEPTIONS AND EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Plan does not provide benefits, nor is any premium charged, for any Medical Treatment not expressly indicated in the Covered Expense section or for any Medical Treatment which is excluded, excepted, or limited in this Policy.

For further clarity, please note that the Plan does not provide benefits, nor is any premium charged, for:

1. Medical Treatment received due to a Pre-Existing Condition or complication thereof in excess of benefits provided elsewhere in this coverage, if any. Medical Treatment for covered Pre-Existing Conditions will be payable under the Policy after the Covered Person's coverage has been in force for six consecutive months. However, a pregnancy which is conceived prior to the Covered Person's Effective Date of Coverage will not be covered under the Policy.
2. Medical Treatment which is not Medically Necessary as defined in the Policy;
3. Medical Treatment which is provided by individuals affiliated with, employed by, or retained by the Participating School, unless the Medical Treatment is provided in a Student Health Center by its providers; which is received in, or provided by individuals affiliated with, the Participating School's athletic department; which is normally provided without charge by an Immediate Family member of the Covered Person; for which no charge is made or for which no payment would be required if the Covered Person did not have this insurance; or which is payable under individual automobile insurance (except for no-fault auto insurance);
4. Medical Treatment required for any Covered Injury or Covered Sickness incurred while the Covered Student is engaged in an occupation (whether paid or unpaid) and which is covered under any occupational benefit plan or any Worker's Compensation or similar employer's liability law;
5. Expenses in excess of the Reasonable and Customary charge, or to the extent the Covered Person received any discount, credit, or reduction due to an agreement with the provider;
6. Hearing aids, eye glasses, or contact lenses and the fitting or servicing thereof, except that the Policy will cover these expenses if the need for such results directly from a Covered Injury or covered eye surgery;
7. Intrauterine devices (IUDs) and birth control implants, including any procedures related to the placement and/or removal of such;
8. Any elective or preventive surgery, including any Medical Treatment required to prepare for or recover from the surgery or procedure. Examples of excluded surgeries or procedures include, but are not limited to: sterilization procedures; sex transformation surgery or the reversal thereof; breast reductions or enlargements (including those for the treatment of benign gynecomastia); circumcisions; correction or treatment of a deviated septum; or, cosmetic, plastic, reconstructive, or restorative surgery;
9. Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges.
10. Medical Treatment related to learning disabilities;
11. Immunizations (except as listed in Covered Expenses), immunization antibody testing, allergy tests, and vitamins;
12. Medical Treatment for injuries sustained in practice for or participation in Intercollegiate Sports in excess of benefits provided elsewhere in this coverage, if any;
13. Medical Treatment for injury or sickness sustained while taking part during the commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
14. Medical Treatment arising out of aeronautics or air travel, except while riding as a passenger on a regularly scheduled commercial airline, in excess of benefits provided elsewhere in the coverage, if any;
15. Medical Treatment received in connection with the teeth, gums, jaw, or structures directly supporting the teeth; myofascial pain; or temporomandibular joint dysfunction in excess of benefits provided elsewhere in the coverage, if any;
16. Medical Treatment for injuries sustained while practicing for or participating in professional sports or while participating in hazardous or adventure sports of any kind, including but not limited to hoverboard usage, hang gliding, skydiving, parachuting, vehicle racing of any kind, any rodeo activity, BASE jumping, kiteboarding, mountaineering or climbing or trekking above elevation 4500 meters above ground level or without proper ropes or guides, luge, motocross, Moto-X, ski jumping, off-piste or off-trail skiing or snowboarding, sub-aquatic activities below 50 meters, whitewater rafting exceeding Class IV difficulty;
17. Medical Treatment for injury or sickness sustained by reason of a motor vehicle or motorcycle accident
    - to the extent that benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such benefits,

- if the Covered Person was operating the motor vehicle or motorcycle while intoxicated or impaired under the laws of the state in which the accident occurred,
- if the Covered Person was operating the motor vehicle or motorcycle without a driver's license or permit recognized as valid under the laws of the state in which the accident occurred, or
- if the Covered Person was not operating the motor vehicle or motorcycle in conformity with the restrictions of the driver's license or permit;

18. Medical Treatment, in excess of benefits provided elsewhere in the coverage (if any), for injury or sickness arising from an intentionally self-inflicted action, suicide, or attempted suicide (while sane or insane); or, resulting from the Covered Person's intoxication, use of illegal narcotics, or use of any controlled substance not prescribed to the Covered Person or intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Physician;
19. Charges incurred for Surgery or treatments which are Experimental/Investigational, or for research purposes or for Compound, Specialty, and Experimental drugs;
20. Medical Treatment involved in the cessation or deterrence of any tobacco use;
21. Medical Treatment or diagnosis of sleep disorders, including but not limited to apnea monitoring and sleep studies;
22. Medical Treatment intended to correct an abnormal or irregular walking pattern by altering slightly the angles at which the foot strikes a walking or running surface;
23. Transcutaneous Electrical Nerve Stimulation (TENS) units;
24. Medical Treatment for infertility, obesity (including bariatric surgery and anorectics), acne, alopecia (loss of hair), or excessive sweating (hyperhidrosis);
25. Lab specimen handling and delivery fees; or after hours and weekend facility fees (unless related to Emergency Services);
26. Genetic medicine, genetic testing, surveillance testing and/or screening procedures for genetically predisposed conditions indicated by genetic medicine or genetic testing, including but not limited to amniocentesis, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine genetic pre-disposition, provide genetic counseling, or administration of gene therapy;
27. Medical Treatment related to any previously known Congenital Condition, whether or not the Covered Person has previously sought treatment for the condition;
28. Private duty nursing and Custodial Care.

Institute Cyber Attack Exclusion Clause

Subject only to the clause immediately below, in no case shall this insurance cover loss damage liability or expense directly or indirectly caused by, contributed to by, or arising from the use or operation, as a means for inflicting harm, of any computer, computer system, computer software programme, malicious code, computer virus or process or any other electronic system.

Where this clause is endorsed on policies covering risks of war, civil war, revolution, rebellion, insurrection, or civil strife arising therefrom, or any hostile act by or against a belligerent power, or terrorism or any person acting from a political motive, the previous paragraph shall not operate to exclude losses (which would otherwise be covered) arising from the use of any computer, computer system or computer software programme or any other electronic system in the launch and/or guidance system and/or firing mechanism of any weapon or missile.

War, Terrorism, and Mass Destruction Exclusion

Notwithstanding any provision to the contrary within this Policy or any endorsement thereto, it is agreed that this insurance or any endorsement thereto excludes any loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss or expense;

- War, hostilities, or warlike operations (whether war be declared or not),
- Participation in the military service of any country,
- Invasion,
- Act of an enemy foreign to the nationality of the insured person or the country in, or over, which the act occurs,
- Civil war, Riot, Rebellion, Insurrection, Revolution,
- Overthrow of the legally constituted government,
- Civil commotion assuming the proportions of, or amounting to, an uprising,

- Military or usurped power,
- Explosions of war weapons,
- Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined,
- Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the insured person whether war be declared with that state or not,
- Terrorist Activity.

For the purpose of this exclusion;

- Terrorist Activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments(s).
- Utilization of Nuclear weapons of mass destruction means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals.
- Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.
- Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals.

Also excluded hereon is any loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any, or all, of the events indicated above. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

Further excludes any loss arising from Nuclear Reaction, Nuclear Radiation, and Radioactive Contamination, whether arising directly or indirectly.