

CERTIFICATE OF COVERAGE

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. 131068 (“the Policy”)

Participating Organization or Institution:	FLORIDA INTERNATIONAL UNIVERSITY
Participating Organization’s or Institution’s Effective Date:	August 20, 2005
Eligible Participant:	See Identification Card Issued to Participant
Eligible Dependents:	See Identification Card Issued to Participant
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a “Covered Person,” and to UNICARE Life & Health Insurance Company as “Insurer.”

This Certificate replaces all certificates previously issued to the Eligible Participant as evidence of coverage under the Policy.

Please call 1-800-696-9776 for assistance regarding claims and information about coverage.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION.

SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES

The Classes eligible for the coverage available under the Policy are shown below.

- Class I: All international students, scholars or other persons with a current passport and student visa (F-1 or J-1 visa) temporarily located outside their home country who have not been granted permanent residency status while engaged in educational activities at the University and their Eligible Dependents who enroll at the time of initial eligibility or when there is a family status change.
- Class II: All Graduate Assistants who have a signed employment agreement on file with the University Graduate School who enroll at the time of initial eligibility or when there is a family status change. The FIU Graduate School must notify UniCare of Eligibility.

All benefits and limits are stated per Covered Person

**SCHEDULE OF BENEFITS
TABLE 1**

**Limits
Eligible Participant**

**COVERAGE A--MEDICAL
EXPENSES**

Lifetime Maximum Benefit \$250,000

Deductible is reduced to 0 if treatment is received at the FIU Student Health Center \$100 per person per Policy Year with a maximum family deductible of \$500

Copayment \$20 per outpatient Physician Visit, Emergency Room \$50 per visit.

Policy Year / Maximum Out-of-Pocket Limit After the Covered Person reaches a \$2,000 (In-Network) and \$4,000 (Out-of-Network) Out-of-Pocket Limit per policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the maximums. Copayments, Deductible and Prescription charges do not apply toward the Out-of-Pocket Limit.

COVERAGE B--ACCIDENTAL, DEATH AND DISMEMBERMENT Maximum Benefit Principal Sum up to \$2,000

**COVERAGE C
REPATRIATION OF
REMAINS** Maximum Benefit up to \$10,000

**COVERAGE D
MEDICAL EVACUATION** Maximum Lifetime Benefit for all Evacuations up to \$25,000.

**DENTAL TREATMENT OF
SOUND NATURAL TEETH** Maximum Benefit is \$200 per accident

SCHEDULE OF BENEFITS
TABLE 2 –
COVERAGE A-MEDICAL EXPENSES

	PPO LIMITS IN NETWORK	OUTSIDE PPO LIMITS
Physician Office Visits *	After \$20 Copayment per visit, 100% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Inpatient Hospital Services	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Hospital and Physician Outpatient Services	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Surgery	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Anesthesia Charges	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Registered Nurse's Services	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Mental Disorders-Inpatient Up to 30 days per policy year	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Mental Disorders-Outpatient Up to 30 visits per policy year	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Emergency Room Expenses Incurred in a hospital, emergency Room, surgical center or clinic (Co-pay waived if admitted)	80% of Reasonable Expenses after \$50 Co-pay per Visit	80% of Reasonable Expenses after \$50 Co-pay per Visit
Diagnostic X-Ray Therapy	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Laboratory Procedures	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Chemotherapy	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Ambulance Service	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Consultant Physician Services	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Dental Treatment for an injury to Sound natural teeth	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses

*\$20 Co-payments for an Injury or Sickness are waived if treatment is received at an FIU Student Health Center.

SCHEDULE OF BENEFITS
TABLE 2 –Continued
COVERAGE A-MEDICAL EXPENSES

Durable Medical Equipment Prescribed by attending Physician	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Routine Newborn Care Up to the first 31 days	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Child Health Supervision Services	After Deductible 80% of Reasonable Expenses	After Deductible, 60% of Reasonable Expenses
Prescription Drugs	80% of Reasonable Expenses	80% of Reasonable Expenses

**SCHEDULE OF BENEFITS
TABLE 3
COVERAGE A--MEDICAL EXPENSE BENEFITS**

BENEFITS LISTED BELOW ARE SUBJECT TO

- 1. TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;**
- 2. TABLE 2 PLAN TYPE LIMITS**

MEDICAL EXPENSE

Eligible Participant and Dependent

Maternity Care for a Covered Pregnancy

Reasonable Expenses

Inpatient treatment of mental and nervous disorders

Reasonable Expenses up to 30 days per Policy Year

Outpatient treatment of mental and nervous disorders

Reasonable Expenses up to 30 visits per Policy Year

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A--MEDICAL EXPENSES

- A. What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable will not exceed the Maximum Benefit of \$250,000 per Lifetime. Benefits are subject to the Deductible Amount, Coinsurance and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, the FIU Student Health Center provision and to all other limitations and provisions of the Policy.
- B. Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below.

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group policy previously offered to a Participating Organization or Institution immediately prior to Policy Effective Date of a group policy administered by the Administrator, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance so long as there was continuous coverage from the previous policy to the current policy.

1. **Physician office visits.**
2. **Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

3. **FIU Student Health Center:** If there is a charge for visits to, or medical services, treatments and supplies received from, the FIU Student Health Center for an Injury or a Sickness, benefits for those visits, medical services, treatments and supplies will be paid at 100% of Reasonable Expenses with no Copayment or Deductible. (Does not apply to Prescription Coverage)

If the FIU Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a provider. If the Covered Person uses the Preferred Provider, medical benefits are paid according to the "Inside PPO" schedule. If the Covered Person chooses not to use the Preferred Provider, medical benefits are paid according to the "Outside PPO" schedule.

C. Additional Covered General Medical Expenses and Limitations: These additional Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below.

1. Pregnancy: The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Conception must have occurred while the Covered Person was insured under the Policy including services of a certified midwife and the services of birthing centers. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
- b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

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

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

2. Mammography screening: Coverage for mammography examination when referred by the Covered Person's Physician for the purposes of breast cancer screening or diagnosis, is as follows:

- a) For women age 35 through age 39, one baseline mammography examination; and
- b) For women age 40 through age 49, one mammography examination every 2 years, or more frequently based on the patient's Physician's recommendation; and
- c) For women age 50 and older, an annual mammography examination.

Except, mammograms done more frequently than every 2 years for women 40 years of age or older, but younger than 50 years of age, benefits are payable with or without a prescription from a Physician if, the Covered Person obtains a mammogram in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast cancer screening.

Additional medically required examinations, based on a Physician's recommendation, will be covered for any woman who:

- a. is at risk because of a personal or family history of breast cancer;
- b. has a history of biopsy-proven benign breast disease;
- c. has a mother, sister, or daughter who has or has had breast cancer; or
- d. has not given birth before the age of 30.

3. Diabetic Supplies/Education: Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.

4. **Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:
1. Reconstruction of the breast on which the mastectomy has been performed;
 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 3. Prostheses;
 4. Treatment for physical complications of all stages of mastectomy, including lymphedemas;
 5. Charges for the inpatient medical care and treatment of a Covered Person following a mastectomy. The length of confinement shall be determined by the attending Physician on the basis of medical necessity in accordance with prevailing medical standards after the attending Physician's evaluation of the Covered Person;
 6. Charges for outpatient postsurgical mastectomy follow-up care in the most medically appropriate setting, which may include a Hospital, the Physician's office, outpatient center, or in the Covered Person's home. Services must be provided by a licensed health care provider acting within the scope of his or her license.

Payment is subject to the Limitations and Conditions on Eligibility for Benefits provision.

5. **Dental Anesthesia:** Charges for dental anesthesia and hospitalization for children under age 8, for persons with developmental disabilities, persons with neurological or other medically compromising conditions or persons with extensive facial or dental trauma.
6. **Child Preventive and Primary Care Services:** Coverage for Physician-delivered or Physician-supervised services for periodic preventive care visits from the moment of birth to age 16. In accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, services to be covered at each visit include: a medical history; a physical examination; developmental assessment and anticipatory guidance; and immunizations and lab tests. Benefits will be limited to one provider per visit for all services rendered. Such services are not subject to the Deductible.
7. **Osteoporosis:** Charges incurred for diagnosis and treatment of osteoporosis. This benefit is provided to a Covered Person who:
- a. Is estrogen-deficient and at risk of osteoporosis; or
 - b. Has a vertebral abnormality; or
 - c. Is receiving long-term glucocorticoid therapy; or
 - d. Has primary hyperparathyroidism; or
 - e. Has a family history of osteoporosis; or
 - f. Has a similar high-risk of osteoporosis.
8. **Cleft Palate:** Charges for the treatment of cleft lip and cleft palate for covered children under the age of 18. Coverage includes medical, dental, speech therapy, audiology, and nutrition services when prescribed by the treating physician.
9. **Enteral Formulas:** Charges for the cost of enteral formulas for home use for which a Physician has issued a written order that states that the enteral formula is clearly medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption. Charges for food products modified to be low protein are included. The Pre-Existing Condition Limitation does not apply to these enteral formula charges.

SECTION 3
COVERAGE B--ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

SECTION 4
COVERAGE C--REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the repatriation of the Covered Person's remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body or visitation or funeral expenses. Any expenses for repatriation of remains require the Insurer's or the Administrator's prior approval.

If an Injury or a Sickness results in the Covered Person's loss of life outside his/her Home Country, the Insurer will pay the Reasonable Expense incurred for cremation or for preparation of the body for burial in, and for transportation of the body to, the Home Country up to the maximum stated for this benefit in Table 1 of the Schedule of Benefits. Payment of this benefit is subject to the Limitations and Conditions on Eligibility for Benefits. No benefit is payable if the death occurs after the Period of Coverage Termination Date. However, if the Covered Person is Hospital Confined on the Period of Coverage Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Period of Coverage Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by either the Insurer or the Administrator before the body is prepared for transportation.

SECTION 5
COVERAGE D--MEDICAL EVACUATION BENEFIT

If a Covered Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to the lifetime Maximum Limit for all medical evacuations shown in Table 1 of the Schedule of Benefits, for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Covered Person's Home Country. Transportation must be by the most direct and economical route. However, before the Insurer makes any payment, it requires written certification by the attending Physician that the evacuation is Medically Necessary. Any expenses for medical evacuation require the Insurer's or the Administrator's prior approval. No benefits are payable under any other provision of the Policy for expense incurred by the Covered Person on and after the date of the evacuation to their home country.

With respect to this provision only, the following is in lieu of the Policy's Extension of Benefits provision: No benefits are payable for Reasonable Expenses incurred after the date the Covered Person's insurance under the Policy terminates. However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 31st day after the date of termination.

SECTION 6
PRE-EXISTING CONDITION LIMITATION

The Insurer does not pay benefits for loss due to a Pre-Existing Condition during the first six (6) months of coverage. However, the Pre-existing Condition will be waived: for those conditions for which medical advice, diagnosis or treatment, including the use of prescription drugs had not been received within the first 6 month period preceding the effective date of coverage or the insured has maintained a minimum of 6 months continuous coverage with the insurance program of the Policyholder or other credible coverage.

SECTION 7
GENERAL POLICY EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health.
2. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
3. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
4. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
5. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
6. Expenses incurred in excess of Reasonable Expenses.
7. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician.
8. Participating in an illegal occupation or committing or attempting to commit a felony.
9. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
10. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
11. Expenses incurred within the Covered Person's Home Country, except when incurred on school-authorized breaks.
12. Treatment to the teeth, gums, including surgical extraction's of teeth dental malocclusion , or other dental treatment.
13. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
14. Diagnosis and treatment of acne and sebaceous cyst.
15. Outpatient treatment for specified therapies including, but not limited to acupuncture.
16. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
17. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion.
18. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
19. Elective termination of pregnancy.
20. Loss arising from participation in professional sports, scuba diving, hang gliding, parachuting or bungee jumping.
21. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
22. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
23. Expenses incurred for treatment of sports-related accidents resulting from interscholastic, intercollegiate, club or professional sports.

SECTION 8 DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Age means the Covered Person's attained age.

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Reasonable Expenses for Medically Necessary treatment. The percentage the Insurer pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

Co-payment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.

Country of Assignment means the country for which the Eligible Participant has a valid passport and, if required, a visa, and in which he/she is undertaking an educational activity.

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, except as stated in the Extension of Benefits provision. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 2 and described in Section 2.

Covered Person means an Eligible Participant and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person per Policy Year basis before certain benefits are payable under the Policy. The Deductible Amounts are stated in the Schedule of Benefits.

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Dependent (Graduate Assistants): An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 25 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption.

Eligible Dependent (for all other Covered Participants): An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 25 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who:

1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and
2. Is temporarily located outside the Eligible Participant's Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Eligible Participant means a person who:

1. Is engaged in international educational activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status; and
4. Graduate Assistants who have a signed employment agreement on file with the University Graduate School

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care:

1. That is provided for an Injury or a Sickness caused by the sudden, unexpected onset of a medical condition with acute symptoms of sufficient severity and pain to require immediate medical care; and
2. In the absence of which one could reasonably expect that one or more of the following would occur:
 - a. The Covered Person's health would be placed in serious jeopardy.
 - b. There would be serious impairment of the Covered Person's bodily functions.
 - c. There would be serious dysfunction of any of the Covered Person's bodily organs or parts.

Experimental or Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the final determination as to what is experimental or investigational.

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a stand-by basis.

Medically Necessary means medical and dental service, treatment or supplies which are:

1. Recommended by the attending Physician;
2. Consistent with generally accepted medical practice for the Injury or Sickness, as determined by the Insurer;
3. Generally considered by Physicians in the United States of America to be appropriate for the Injury or Sickness; and
4. Accepted as safe, effective and reliable by a medical specialty or board recognized by the American Board of Medical Specialties or as determined as prevailing in the geographic locality where and at the time the service or supply is rendered.

A medical or dental treatment will not be deemed Medically Necessary if the Insurer determines that any service, supply or treatment used or provided in connection with the Injury or Sickness is Experimental or Investigational in nature. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary. If services do not meet the criteria above or are not consistent with professionally recognized standards of care with respect to quality, frequency or duration, such services will not be deemed Medically Necessary.

Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile “no fault” and “traditional fault” type contracts.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Out-of-Pocket Limit means the amount of Reasonable Expenses which the Covered Person must pay after which the Insurer pays 100% of the reasonable Expenses, subject to the limits and provisions of the Policy. Copayments, Deductibles and Prescription charges do not apply to this limit.

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician’s office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

Outpatient treatment facility means a clinic, counseling center, or other similar location that is certified by the District or by any state or territory as a qualified provider of outpatient services for the treatment of drug abuse, alcohol abuse, or mental illness. The term “outpatient treatment facility” includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Policy Year means the period beginning on the Participating Organization’s or Institution’s effective date. It includes the period beginning on the date a Covered Person’s coverage under the Policy starts.

Preferred Provider means a Hospital, Physician, or other health care provider who has agreed to participate in the PPO.

Preferred Provider Organization (PPO) means the network(s) of Preferred Providers stated on the Insured Person’s identification card.

Pre-Existing Condition means any Injury or Sickness which had its symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received prior to the Covered Person’s effective date of coverage. A pre-existing condition does not include routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer unless evidence of breast cancer is found during or as a result of the follow-up care.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

Recognized Student Health Center(FIU) means a health facility of an educational institution that provides basic health services for students hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider and is approved as a Recognized Student Health Center by the Administrator.

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." or "R. P.N." after his/her name.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person .

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
 - a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
 - b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

Written Request means a request on any form provided by the Administrator for particular information.

**SECTION 9
EXTENSION OF BENEFITS**

No benefits are payable for medical treatment benefits after the Covered Person's insurance terminates. If the Policy is terminated, coverage will be extended for a Covered Person who:

1. Is Totally Disabled on the date coverage ends ;or
2. Is pregnant on the date coverage ends if the pregnancy commenced while insurance was in force under the Policy.or
3. If a dentist recommended continuation of dental treatment in writing and there is no coverage under a succeeding contract.

Coverage under this provision is provided only for Covered Medical Expenses or Dental Expenses with respect to:

1. A Totally Disabled Covered Person, for the condition causing the Total Disability;
2. A pregnant Covered Person, for that pregnancy, childbirth or miscarriage; and
3. A Covered person requires dental treatment and there is no coverage under the succeeding contract.

Coverage so extended will end on the first of the following to occur:

1. 12 months following termination of the Policy; or
2. The date the Total Disability ends;
3. The end of the pregnancy; or
4. For dental treatment, 90 days following termination or completion of treatment, whichever occurs first..

Except as stated above, coverage is not provided for any expense incurred after the date the Policy terminates.

SECTION 10

COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any policy year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

The term “plan” applies separately to each policy, contract agreement or other arrangements for benefits or services. The term “plan” also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid. The entire liability will be included in the coordination of benefits computations.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If this primary plan’s payment is less than the charge for the allowable expense, then the second-paying (secondary) plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
 - a. First, benefits of a plan covering persons as an employee, member, or subscriber.
 - b. Second, benefits of a plan of an active worker covering persons as a dependent.
 - c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
 - a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
 - b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
 - c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
 - d. When the parents are separated or divorced and the parent with custody has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.

- f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits.
5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
 - a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. When rules 2 through 5 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by the Insurer, the Insurer has the right to pay the other plan any amount the Insurer deems necessary to satisfy the Insurer's obligation under these COB rules.

Right of Recovery. If the amount of the Insurer's benefit payment is more than the amount needed to satisfy the Insurer's obligation under these COB rules, the Insurer has the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. The Insurer has the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as the Insurer deems necessary; and
2. Any person claiming benefits under this plan must give the Insurer any information necessary to carry out this provision.

SECTION 11
ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1—Eligible Classes. He/she must not be insured under the Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.

Enrollment for Coverage: An Eligible Participant will be eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or
2. The effective date shown on the Insurance Identification Card, if any;
3. The date the requirements in Section 1 - Eligible Classes are met; or

The insurance is effective 24 hours a day.

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
2. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
3. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country; except when on a school-authorized break;
4. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
5. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

Coverage will end at 11:59:59 pm. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

When an Eligible Dependent's Coverage Starts: An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

You must give the insurer written notice within 30 days of the birth or placement of a dependent. If timely notice is given, the insurer will not charge an additional premium for the notice period. If timely notice is not given, the insurer will charge the applicable additional premium from the date of birth for newborns or the date of placement in the residence for an adopted child. The insurer will not deny coverage for a child due to your failure to notify the insurer within the 30 day period of the birth of the child.

1. The effective date of the Policy; or
2. The effective date of the Eligible Participant's insurance;
3. The effective date shown on the insurance identification card, if any;
4. The date the eligibility requirements in this section are met; or

The insurance is effective 24 hours a day.

When an Eligible Dependent's Coverage Ends. An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates; or
2. The date the Eligible Participant is no longer covered under the Policy;
3. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;
4. 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country, except when on a school-authorized break;
5. The date the Covered Person requests cancellation of coverage (the request must be in writing);
6. The premium due date for which the required premium has not been paid, or
7. The date on which the dependent ceases to meet the eligibility requirements.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.

SECTION 12
COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants

You must give the Insurer written notice within 30 days of the birth or placement of a dependent to obtain additional premium information. Please see Section 11 Requirements and Period of Coverage (When an Eligible Dependent's Coverage Starts). The coverage start date of insurance for the child will be the date of birth. Coverage will be to the same extent as is provided for other covered dependent children and subject to the particular coverages and amounts of insurance as specified for eligible dependents in the schedule of benefits. Coverage consists of coverage for Injury or Sickness, including:

1. The Necessary Care and Treatment of medically diagnosed congenital defects;
2. Birth abnormalities;
3. Prematurity;
4. Transportation of the child to and from the nearest facility staffed and equipped for the treatment of the child. Transport must:
 - a. Be by a licensed ambulance service; and
 - b. Be certified by the attending Physician as necessary to protect the health and safety of the child.
5. Routine nursery care up to the limits, if any, shown in the Schedule of Benefits.

Coverage of Adopted Children

With respect to an adopted child, a foster child, or other child in court-ordered temporary or other custody, coverage will be effective from the date of placement for the purposes of adoption or from the date of birth if a written agreement to adopt such child was entered into prior to the date of birth as shown in Section 11 Eligibility Requirements and Period of Coverage (When an Eligible Dependent's Coverage Starts). Coverage will not be required if such child is not placed in the Eligible Participant's residence following birth. Such coverage will include the necessary care and treatment of medical conditions existing prior to the date of placement.

You must give the Insurer written notice within 30 days of the birth or placement of a dependent to obtain additional premium information. Please see Section 11 Requirements and Period of Coverage (When an Eligible Dependent's Coverage Starts). Coverage for a dependent child will continue after birth until proper notice has been furnished to the Eligible Participant as to the amount of any additional premium for such child's coverage. All liability with respect to such child shall terminate at the end of 61 days after notice has been furnished to the Eligible Participant, unless on or before such 61st day, the additional premium, if any, has been paid to the Insurer, or to the Insurer's licensed agent who is authorized to receive such premium payment.

Coverage of Newborn Children of a Covered Son or Daughter

All liability with respect to a newborn child of a covered son or daughter including coverage for newborn children of a covered son or daughter who are mentally retarded or physically handicapped will end on the earliest of:

1. The date the Eligible Participant's insurance terminates;
2. The date the newborn child is 18 months old.

SECTION 13
PREMIUM
For Individual Enrollment

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid semi-annually, annually, or for a specified term, as arranged with the Administrator. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Covered Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Renewing Coverage: Coverage for all Covered Persons shall be continuous if the acceptable renewal form and premium are received by the Insurer prior to the expiration of coverage.

SECTION 14 CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer are liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

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

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Policy which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

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

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

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

SECTION 15 GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Participating Organization or Institution, and copies of which are attached to and made a part of the Policy. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Policy has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Policy unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after 2 years from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

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

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

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Policy.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

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

Not in Lieu of Workers' compensation. The Policy does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the Right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

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

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