MONUMENTAL LIFE INSURANCE COMPANY
(Herein, "we," "us," "our" or "the Company")
Home Office: 4333 Edgewood Road N.E. Cedar Rapids, Iowa 52499
Administrative Office: 520 Park Avenue, Baltimore, Maryland 21201

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE This Policy and the insurance provided by it become effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below.

This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS FOLLOWS:

Domestic students	$15,000
International students	$25,000
J-1 Visa students	$50,000

GROUP INSURANCE POLICY
INJURY AND SICKNESS MEDICAL EXPENSE INSURANCE
NON-PARTICIPATING
NON-CONTRIBUTORY

N Stacey Boyer
Secretary

Brenda Clancy
President

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SCHEDULE OF BENEFITS

Group Policy Number: CCT302H

Effective Date: August 1, 2011

Expiration Date: August 1, 2012

Plan Administrator: Bollinger, Inc.

The Policyholder: UNIVERSITY OF NEW HAVEN

Preferred Provider Network: First Health

(referred to as you, your, and yours)

PLAN OF INSURANCE

PREFERRED PROVIDER ORGANIZATION PLAN

To locate a Preferred Provider in Your area, consult Your Provider Directory or call toll free 866-267-0092 or visit Our website at www.bollingercolleges.com.

This Policy provides benefits for expenses incurred by a Covered Person for loss due to a covered Injury or Sickness. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. The following is an outline of the Maximum Benefit amounts provided.

MAXIMUM BENEFIT

Maximum Benefit per Covered Person
for each Injury or Sickness per Policy Year

Domestic students	$15,000
International students	$25,000
J-1 Visa students	$50,000

Preferred Provider Coinsurance Amount 20%

Non-Preferred Provider Coinsurance Amount 40%

The Preferred Provider Organization will not charge a Covered Person or his or her enrolled Dependents for any balances beyond the Deductible, Co-payment and Coinsurance amounts for covered expenses. Balances over the payment level, Deductible and Coinsurance do not apply to your out-of pocket Maximum.

Facilities and professional providers that are not contracted with the Preferred Provider Organization, may bill a Covered Person for any balances over the payment level in addition to the Deductible and Coinsurance amount. Balances over the payment level, Deductible and Coinsurance do not apply to the out-of pocket Maximum.

OPTIONAL RIDERS

Intercollegiate Sports Benefit Rider..... $7,000
Preferred Providers.....100% Preferred Allowable Charge
Non-Preferred Provider Providers .....80% Usual and Customary Charge

PAC = Preferred Allowable Charge
U&C = Usual & Customary Charges
AC = Actual Charge

Additional Benefits for Domestic Students Only

Room and Board Allowance .....semi-private room rate
Maximum number of days per Injury or Sickness ..... up to 3 days
Preferred Providers.....100% PAC
Non-Preferred Provider Providers ..... 100% U&C

Room and Board Allowance .....semi-private room rate
Maximum number of days per Injury or Sickness..... up to 28 additional days
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Intensive Care Benefit .....
Maximum number of days per Injury or Sickness.....N/A
Preferred Providers.....100% PAC
Non-Preferred Provider Providers ..... 100% U&C

Miscellaneous Hospital Expenses Benefit .....
Maximum benefit $5,000
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Outpatient Miscellaneous Expense .....
Maximum benefit $1,100
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Ambulance Benefit
Maximum benefit (unless admitted to Hospital).....$500
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Attending Physician Benefit
Maximum benefit .....N/A
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Additional Benefits for Domestic Students Only

Physician's Office Visit
Maximum benefit .....paid under Outpatient Miscellaneous Expense
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Dental Injury Expense Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 80% U&C

Dental Injury Expense Benefit – removal of impacted wisdom teeth
Maximum benefit .....$100 per tooth
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 80% U&C

Diagnostic Benefit
Maximum benefit .....paid under Outpatient Miscellaneous Expense
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C
(Dental training students – HIV testing accidents only ..... 100% of the usual and customary charge)

Durable Medical Equipment Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 80% U&C

Elective Abortion Benefit
Up to 12 weeks.....$400
Up to 14 weeks.....$750
Over 14 weeks…… $1,000
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Medical Consultation Benefit
Maximum benefit .....paid under Outpatient Miscellaneous Expense
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Physical Therapy Benefit
OUTPATIENT
Maximum benefit .....paid under Outpatient Miscellaneous Expense
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Private Duty Nurse Benefit
Maximum benefit .....paid under Outpatient Miscellaneous Expense
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Additional Benefits for Domestic Students Only

Radiology and Chemotherapy Benefit
Injury $0
Sickness ..... see benefit rider
Preferred Providers ..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Second Surgical Opinion Benefit
Maximum benefit ..... paid under Outpatient Miscellaneous Expense
Preferred Providers ..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Surgical Expense Benefit
Maximum benefit $1,500
Preferred Providers ..... 100% PAC
Non-Preferred Provider Providers ..... 80% U&C

Anesthesiologist
Preferred Providers ..... 30% of Surgical Expense Benefit
Non-Preferred Provider Providers ..... 30% of Surgical Expense Benefit

Assistant Surgeon Benefit
Preferred Providers ..... 30% of Surgical Expense Benefit
Non-Preferred Provider Providers ..... 30% of Surgical Expense Benefit

Prescription Drugs Benefit ..... $1,000 per Policy Year for prescriptions
..... filled at a Caremark Pharmacy

Additional Benefits for International Students Only

Room and Board Allowance ..... semi-private room rate
Maximum number of days per Injury or Sickness ..... N/A
Preferred Providers ..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Intensive Care Benefit
Maximum number of days per Injury or Sickness ..... N/A
Preferred Providers ..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Miscellaneous Hospital Expenses Benefit
Maximum benefit ..... N/A
Preferred Providers ..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Additional Benefits (continued)

Additional Benefits for International Students Only

Outpatient Miscellaneous Expense
Maximum benefit – domestic only ..... N/A
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Ambulance Benefit
Maximum benefit ..... N/A
International students ..... 80% of the usual and customary charge
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Attending Physician Benefit
INPATIENT
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Physician's Office Visit
Maximum benefit ..... paid under Outpatient Miscellaneous Expense
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Dental Injury Expense Benefit
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 80% U&C

Dental Injury Expense Benefit – removal of impacted wisdom teeth
Maximum benefit ..... N/A
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Diagnostic Benefit
Maximum benefit ..... N/A
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 60% U&C
(Dental training students – HIV testing accidents only ..... 100% of the usual and customary charge)

Durable Medical Equipment Benefit
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 80% U&C

Elective Abortion Benefit
Up to 12 weeks..... $400
Up to 14 weeks..... $750
Up to 16 weeks..... $1,000
Preferred Providers..... 80% PAC
Non-Preferred Provider Providers ..... 80% U&C

Additional Benefits for International Students Only

Medical Consultation Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Physical Therapy Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Private Duty Nurse Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Radiology and Chemotherapy Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Second Surgical Opinion Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Surgical Expense Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Anesthesiologist
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Assistant Surgeon Benefit
Preferred Providers.....80% PAC
Non-Preferred Provider Providers ..... 60% U&C

Prescription Drugs Benefit..... $1,000 per Policy Year for prescriptions
.....filled at a Caremark Pharmacy

Medical Evacuation Benefit (International students)..... Up to $10,000

Repatriation Expense Benefit (International students) ..... Up to $10,000

MANDATED BENEFITS (page 20 for details) As requested by Policyholder, benefits may be paid in addition to the mandated benefits. PAC = Preferred Allowable Charge U&C= Usual & Customary Charges AC = Actual Charge	Preferred Providers	Non-Preferred Provider Providers
Accidental Ingestion of a Controlled Drug	80% PAC	60% U&C

Benefit Inpatient-Maximum 30 days per Calendar Year Outpatient-Maximum of $500 per Calendar Year		
Clinical Trials	80% PAC	60% U&C
Colorectal Cancer Screening Benefit Maximum Testing once every three years	80% PAC	60% U&C
Craniofacial Disorders Benefit	80% PAC	60% U&C
Cytology Benefit	80% PAC	60% U&C
Dental General Anesthesia Benefit Inpatient/Outpatient Hospital	80% PAC	60% U&C
Diabetes Supplies, Equipment and Self-Management Training Benefit	80% PAC	60% U&C
Early Interventions Services Benefit Up to $3200 per year and an aggregate benefit of $9600 over a total 3 year period per Dependent Child	80% PAC	60% U&C
Emergency Ambulance Benefit	80% PAC	60% U&C
Hearing Aid Benefit Up to $1000 every 24 months	80% PAC	60% U&C
Home Health Care Benefit Maximum numbers of visits 80 per Injury or Sickness	80% PAC	60% U&C
Hypodermic Needle and Syringes Benefit	80% PAC	60% U&C
Infertility Diagnosis and Treatment Benefit	80% PAC	60% U&C
Leukemia Treatment Benefit Maximum Benefit for Wigs	80% PAC	60% U&C
Lyme Disease Treatment Benefit	80% PAC	60% U&C
Mammography Benefit Age 35 to 39 (baseline) - inclusive Age 40 and over-one per Policy Year	80% PAC	60% U&C
Maternity Benefit Maximum hours for uncomplicated vaginal delivery - 48 hours Maximum hours for cesarean section- 96 hours	80% PAC	60% U&C
Medical Complications of Alcoholism Treatment Benefit	80% PAC	60% U&C
Medical Foods	80% PAC	60% U&C
Mental & Nervous Conditions Expense Benefit, Including Alcohol Dependency and Substance Abuse	80% PAC	60% U&C
Neuropsychological Testing Benefit	80% PAC	60% U&C

Ostomy Appliances and Supplies Benefit	80% PAC	60% U&C
Pain Management Benefit	80% PAC	60% U&C
Post-Mastectomy or Lymph Node Dissection Benefit	80% PAC	60% U&C
Prostate Cancer Screening Benefit	80% PAC	60% U&C
Well Child Care Benefit	80% PAC	60% U&C
Wound Care Benefit	80% PAC	60% U&C
CONDITIONAL MANDATED BENEFITS		
Off-Label Cancer Drug Use Benefit	Same as any other Prescription Drug	Same as any other Prescription Drug

DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL CHARGE means the fee charged by the Physician or Hospital for a Covered Service.

AGGREGATE MAXIMUM BENEFIT means benefits for any one Injury or Sickness which are payable throughout a period of Continuous Coverage. Benefits will terminate at the end of a period of Continuous Coverage, subject to an Aggregate Maximum Benefit for any one Injury or Sickness as shown on the Schedule of Benefits.

COINSURANCE means the out-of-pocket expenses to be paid by the Insured as a percentage of the Covered Medical Expenses.

COMPLICATIONS OF PREGNANCY means conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as:

(1) acute nephritis;
(2) nephrosis;
(3) cardiac decompensation;
(4) missed abortion;
(5) non-elective cesarean section;
(6) ectopic pregnancy which is terminated;
(7) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible;
(8) pernicious vomiting;
(9) pre-eclampsia;
(10) similar medical and surgical conditions of comparable severity.

It does not include:

(1) false labor;
(2) occasional spotting;
(3) Physician's prescribed rest;
(4) morning Sickness; and
(5) similar conditions associated with the management of a difficult pregnancy not constituting a medically distinct Complication of Pregnancy.

CONFINED OR CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The term "Inpatient" is the same as Confined under this Policy.

Confinement does not include treatment received in the Outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

CONTINUOUS COVERAGE means that period of time during which the Insured Person is continuously covered under one of the University of New Haven Student Injury and Sickness Plans, with no lapse in coverage between this Policy and the prior policies.

CO-PAYMENT means a fixed dollar amount paid by a Covered Person to a Preferred or Non-Preferred Physician, Hospital, pharmacy, or other health care provider at the time the Covered Person receives Covered Services.

COSMETIC and RECONSTRUCTIVE PROCEDURES and SERVICES means (1) procedures and related services that are performed to reshape structures of the body in order to alter a person's appearance; and (2) procedures and related services that are performed on structures of the body to improve/restore bodily functions or appearance resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

COVERED MEDICAL EXPENSES are usual, customary, and Medically Necessary charges that are:

(1) not in excess of the Maximum amount payable for services as specified in the Schedule;
(2) in excess of any Deductible amount; and
(3) incurred while the Covered Person's coverage under this Policy is in force.

COVERED PERSON means the Insured or a Dependent for whom an application has been received and the required premium has been paid.

COVERED SERVICE means service by or under the direct supervision of a Physician or licensed psychologist, when performed in a Physician's or licensed psychologist's office, Hospital, in a community mental health facility or in an alcoholism treatment facility.

DEPENDENT means the Insured's spouse, unless they are legally separated; the Insured's unmarried children under age **27** and children whose support is required by a court decree.

Children include natural children, stepchildren, foster children and legally adopted children. Newborn children are covered from the moment of birth and from the moment of a signed placement with the adoptive parents for adopted children.

A spouse or child who is covered under this Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both insured as Students, a child will be the Dependent of only one.

ELECTIVE SURGERY AND ELECTIVE TREATMENT means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under this Policy.

Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; allergy and allergy vials, including allergy testing; bio-feedback type services; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are

otherwise payable under this Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under this Policy; deviated nasal septum, including submucous resection and/or other surgical correction; family planning; fertility tests; hair growth or removal; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia or any kind), except for the treatment of an underlying covered Sickness; premarital examinations; preventive medicines or vaccines, except where required for the treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing; smoking cessation; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

HOSPITAL means an institution which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility. It is not a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

IMMEDIATE FAMILY means the Insured's spouse and the children, brothers, sisters, uncles, aunts, in-laws, and parents of the Insured and of the Insured's Spouse.

INJURY means bodily injury caused by an accident. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

INSURED means an eligible student as outlined in this Policy and has paid the required premium. The words he, his, and him refer to the Insured.

LICENSED THERAPIST means a physical therapist, occupational therapist, respiratory therapist, physiotherapist, chiropractor, osteopath, certified athletic trainer, speech pathologist, or audiologist who is licensed in the state where the care is rendered.

MAXIMUM BENEFIT means the maximum amount payable for expenses incurred by a Covered Person for any one Injury or Sickness.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in death, permanent placement of Covered Person's health in jeopardy, serious impairment of bodily functions or serious and permanent dysfunction of any body organ or part. Expenses incurred for a Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

MEDICALLY NECESSARY means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, " generally accepted standards of medical practice " means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

MENTAL or NERVOUS DISORDERS means any disorder specified in the diagnostic and statistical manual of mental disorders, forth edition (DSM-IV, 1995) or revised versions, of the American Psychiatric Association. This will not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, V Codes).

NON-PREFERRED HEALTH CARE PROVIDER Any individual or organization, including, but not limited to, Physicians, psychologists, nurse practitioners, physical therapists, Hospitals, substance abuse treatment centers, residential treatment centers, skilled nursing facilities, and laboratories, x-ray, MRI or other radiological centers, licensed to provide health care services in Connecticut, but which has not contracted or is not affiliated with the Preferred Provider Organization.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). He may not be the Insured or a member of his Immediate Family.

OTHER VALID and COLLECTIBLE MEDICAL INSURANCE includes but is not limited to group insurance; automobile medical payments and no-fault insurance; individual major medical policies; coverage provided by a Hospital or medical service organization; union welfare plans; or employer or employee benefits organization; or employer's liability coverage.

OUTPATIENT EXPENSES means expenses incurred for Medically Necessary services received other than as Confined.

PARTICIPATION IN A RIOT means promotion, conspiring to promote or incite, aiding, abetting or all forms of taking part in a riot but shall not include action taken in a Covered Person’s defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order, including, but not limited to police officers and firefighters. Riot shall mean all forms of violence, disorder, or disturbance of the public place by three or more

persons assembled together, whether or not acting with common intent or whether or not damage to persons or property or unlawful act of acts is the intent or the consequence of such disorder, violence or disturbance.

PARTICIPATING ORGANIZATION means a college, university or other educational sponsor that has endorsed or offered the insurance provided by this Policy to its students. The term "University" is also used to refer to Participating Organization.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. He may not be the Insured or a member of his Immediate Family.

PHYSICAL THERAPY means rehabilitation concerned with restoration of function and prevention of disability following Sickness, Injury, disease, or loss of body part.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule of Benefits. The terms you, your, and yours mean the Policyholder.

POLICY YEAR means the period of time starting with the Effective Date of this Policy through the Termination Date of this Policy as shown on the Schedule of Benefits. The Policy Year is agreed to by the Policyholder and the Company.

PREFERRED ALLOWABLE CHARGE means the contracted amount that the Preferred Provider agrees to accept as payment in full. Covered Medical Expenses incurred at a non-Preferred Provider will be based on the Usual and Customary Charge.

PREFERRED HEALTH CARE PROVIDER A facility, organization, or individual person who has a contract with First Health/Coventry to provide certain health care and/or related services to Covered Persons of carrier. Any reference to Preferred Provider in this Policy shall also mean any subcontractor, employee, agent, or other individual person or entity providing Covered Service on behalf of the Preferred Provider.

PREFERRED PROVIDER ORGANIZATION means a diversified group of medical providers who have entered into agreements with the insurance carrier to provide medical benefits and services to the Covered Persons.

PRESCRIPTION DRUGS means any Medically Necessary drugs that, under the applicable state or federal law, may be dispensed only upon written prescription of a Physician; and injectable insulin.

SICKNESS means an illness, or disease, or trauma related disorder due to Injury which first manifests or causes a loss while this Policy is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes Complications of Pregnancy.

SKILLED NURSING FACILITY means an institution which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be primarily engaged in providing in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(3) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(4) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

UNIVERSITY HEALTH CENTER SERVICES means the health center at the school the Insured is attending and any other facility appointed by the school for medical care and approved by the Plan Administrator.

USUAL AND CUSTOMARY CHARGE means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service delivered.

ELIGIBILITY AND ENROLLMENT

Eligibility - Students who: 1) are enrolled during the Fall and/or Spring and/or Summer Semester at the University named in the Schedule; and 2) carry 12 or more credit hours for undergraduate students and 9 or more credit hours for graduate students; and have paid all registration and tuition fees become Insureds.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. We maintain the right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever we discover that the policy eligibility requirements have not been met, our only obligation is refund of premium.

Eligible students who do enroll may also enroll their Dependents. Eligible Dependents are the spouse and unmarried children under **26** years of age. Dependent eligibility expires concurrently with that of the Insured student. Coverage will coincide with the period for which the Insured student is covered or the date the premium and application are received by the plan administration, whichever is later.

INDIVIDUAL EFFECTIVE AND TERMINATION DATES

Each eligible Insured will become insured under this Policy on the effective date shown on the Schedule of Benefits or, in the case of open Enrollment, on the date full premium is received by the Company, whichever is later.

Any required premium for newborn Dependents must be paid within 31 days to continue coverage beyond 31 days.

If a Covered Person is Confined for any condition in a Hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal discharge from the Hospital or institution.

NEWBORN CHILDREN

Coverage for a Covered Person's newborn child will be effective from the moment of birth. Coverage will include any needed care or treatment for medically diagnosed congenital defects or birth abnormalities. Coverage will include expenses incurred for Well Baby Care, well baby nursery and related Physician charges up to 48 hours after birth or limited to the length of time that the newborn and the mother are both Hospital Confined. Notification and additional premium for a newborn child must be received by the Company within 31 days after the child's birth for coverage to continue beyond this 31 day period. If the additional premium is not paid, the benefit for the first 31 days will be paid as shown on the schedule.

CREDIT FOR PRIOR COVERAGE

This Policy provides portability of coverage as it relates to “pre-existing conditions”. The pre-existing condition limitation set forth in this Policy will be reduced to the extent an Insured Person was covered under a Qualifying Previous Coverage if: 1) the person is not a late enrollee; and 2) the prior coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage, exclusive of any applicable waiting period.

Any pre-existing limitation is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the Insured Person as of the enrollment date, for similar services covered under this Policy and the prior coverage.

Qualifying Previous Coverage means coverage of the Insured Person under any of the following: 1) An employee sponsored plan; 2) health benefit plan; 3) Part A or Part B of Title XVIII of the Social Security Act; 4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; 5) Chapter 55 of Title 10 of the United States Code; 6) a medical care program of the Indian Health Service or of a tribal organization; 7) a state health benefits risk pool; 8) a health plan offered under the Federal Employees Health Benefits Program (FEHBP), Title 5, Chapter 89 of the United State Code; 9) a public health plan as defined by federal regulations authorized by the Public Health Service Act, §2701(c)(1)(i), as amended by P.L. 104-191; or 10) a health benefit plan under §5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 120 day period during all of which the individual was not covered under any creditable coverage.

Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, shall not be taken in to account in determining the period of creditable coverage.

Credit For Time Covered
If the Insured Person was insured under a prior plan that this plan replaces and replacement is effective within sixty-three days of the termination date of the prior plan, then credit will be given for each day of coverage under the prior plan towards satisfaction of the 180 day limitation on pre-existing conditions. Credit will be given only for those benefits for which the prior plan contained which are also contained in this Policy.

TERMINATION OF COVERAGE

The insurance of any Covered Person will immediately terminate on the earliest of:

(1) the date to which the premium is paid;
(2) the date this Policy expires as shown on the Schedule of Benefits, subject to the Extension of Benefits After Termination provision;
(3) the date of entrance into the armed forces of any country, a pro-rata portion of the premium paid will be returned; or
(4) the date the Covered Person no longer meets the conditions of eligibility for coverage, except the limiting age shall not operate to terminate the coverage of a Dependent Child if at such date the child is and continues thereafter to be both incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's Physician on a form provided by Us and (2) chiefly dependent upon the Insured for support and maintenance. Proof of the incapacity and dependency shall be furnished to Us by the Insured within 31 days of the child's attainment of the limiting age. We may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age We may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year; or
(5) the date the Covered Person enrolls in Medicare.

Termination will be made without prejudice to any existing expense. Coverage for any Insured who leaves the school before the end of the semester will continue in force through the end of the period for which a premium was paid.

BENEFIT PROVISIONS

This Policy and any riders attached provide benefits for Covered Medical Expenses incurred by a Covered Person that are:

(1) Usual, Customary, and Medically Necessary;
(2) incurred after the Covered Person's effective date of coverage;
(3) incurred while this Policy is in force;
(4) due to a covered Injury or Sickness;
(5) in excess of the appropriate Deductible amount;

(6) incurred within 52 weeks from the date of accident or date of first treatment during the Policy period for Sickness; incurred within 104 weeks from the date of accident or date of first treatment during the Policy period for Injury.

All benefits provided are subject to all the provisions, terms and conditions of this Policy.

After the appropriate Deductible amount has been met, Covered Medical Expenses will be payable according to benefit limits specified on the Schedule of Benefits, including any Coinsurance requirements.

Unless otherwise stated benefits are paid per Injury or Sickness. Unless otherwise stated benefits are subject to a Coinsurance requirement.

Covered Persons will be covered at home, at school and while traveling, 24 hours a day during each semester for which a premium has been paid.

USE OF UNIVERSITY HEALTH CENTER SERVICES

The coverage under this Policy supplements the services provided at the University Health Center**.** The coverage under this Policy is designed to supplement, not to replace the services of the University's Health Center**.**

The Insured is strongly encouraged to use the resources of the Student Health Center when first seeking medical treatment. Treatment will be either administered at the Health Center or a referral to another facility will be given.

Student Health Center referral will not be required under the following conditions:

(1) a Medical Emergency. The student is strongly encouraged to return to the Health Center for any needed follow-up care;
(2) when the Health Center is closed;
(3) when service is rendered at another facility during school break or vacation periods;
(4) when Necessary Medical service is received and the Insured is more than 25 miles from the campus;
(5) when Necessary Medical care is obtained and the Insured is no longer able to use the Health Center due to a change in student status;
(6) maternity care;
(7) Psychiatric Care; and
(8) services not offered by the Health Center.

PREFERRED PROVIDER ORGANIZATION (PPO) AGREEMENT

The benefits outlined in this Policy are based upon medical treatment being received from one of the participating providers shown on a list available at the Health Center.

If a Covered Person seeks treatment from a nonparticipating provider, any benefits payable under this Policy or Rider attached thereto will be reduced and paid only at the rate shown on the Schedule of Benefits. The only exceptions to this provision are:

(1) a Medical Emergency;

(2) or the service to be performed was not available at a Preferred Provider Organization facility. (Proof must be presented with the claim.)

MEDICAL EMERGENCY SERVICES

In the event of a Medical Emergency, a Covered Person has the option of calling a local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a Covered Person is confronted with a Medical Emergency which in the judgment of a prudent layperson would require pre-hospital emergency services.

Medical Emergency services provided in an emergency room or other licensed facility to a Covered Person who presents himself with a Medical Emergency condition will be paid as shown on the Schedule of Benefits subject to any Coinsurance and Deductible requirements.

BASIC MEDICAL EXPENSE COVERAGE

The Schedule of Benefits shows Benefits levels, Coinsurance and Maximums for Preferred Health Care Provider and Non Preferred Health Care Provider. Benefit Level Maximums are the equal for both Preferred Provider and Non-Preferred Provider.

ROOM AND BOARD ALLOWANCE Benefits will be payable when a Covered Person incurs a daily charge for Room and Board while Hospital Confined in a semi-private room or approved intensive or cardiac care units. Daily semi-private room benefits are limited as stated in the Schedule of Benefits, subject to any Coinsurance requirement.

MANDATED BENEFITS

Accidental Ingestion of a Controlled Drug Benefit

Upon receipt of due proof that a Covered Person incurred expenses for emergency medical care arising from the accidental ingestion or consumption of a Controlled Drug, we will pay benefits as listed in the Schedule of Benefits for:

In-Patient: In the event that Covered Expenses are incurred in connection with confinement as an in-patient in a Hospital (including a state institution), then such expenses are covered to the same extent as a Sickness. The maximum period benefits are payable is limited to 30 days in any Policy Year.
Out-Patient**:** With respect to those covered expenses which are incurred by the Covered Person while other than an in-patient in a Hospital, expenses are covered to the same extent as any other Sickness, up to a maximum of $500 per Policy Year.

For purposes of this Benefit, a Controlled Drug means those drugs which contain any quantity of a substance that:
1) has been designated as subject to the Federal Controlled Substances Act; or
2) has been designated as a depressant or stimulant drug pursuant to federal food and drug laws; or
3) has been designated by the Commissioner of Consumer Protection as having a stimulant, depressant or hallucinogenic effect on the higher functions of the central nervous system.

The drug must also have been designated as having a tendency to promote abuse or psychological or physiological dependence, or both.

Such Controlled Drugs are classified as:
1) Amphetamine-type;
2) Barbiturate-type;
3) Cannabis-type;
4) Cocaine-type;
5) Hallucinogenic;
6) Morphine-type; and
7) Other stimulant and depressant drugs.

Specifically excluded from Controlled Drugs are alcohol, nicotine and caffeine.

Clinical Trials Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Routine Patient Care Costs as the result of phase II, III or IV of a clinical trial that is approved by an Entity and is undertaken for the purposes of the prevention, early detection or treatment of cancer, We will pay benefits as listed in the Schedule of Benefits.

In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Benefits will include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Benefits for routine patient care costs shall apply to phase III or IV of clinical trials that are approved or funded by an Entity.

Benefits for routine patient care costs shall apply to phase II of clinical trials if:

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

We will pay Benefits as listed in the Schedule of Benefits.

Definitions

Entity means any of the following:

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Cooperative group means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

Multiple project assurance contract means a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

Routine patient care costs mean coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(1) The investigational item or service itself;

(2) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(3) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Colorectal Cancer Screening Benefit

Upon receipt of due proof that a Covered Person incurred expenses for colorectal cancer screening for the detection of colorectal cancer, we will pay benefits as listed in the Schedule of Benefits for:

1) colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for a Covered Person who is at least 50 years old ; and

2) for each male Covered Person age 50 and over and asymptomatic or for each male Covered Person age 30 and over classified as high risk for colorectal cancer because the Covered Person or a first degree family member of the Covered Person has a history of colorectal cancer.

Craniofacial Disorders Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Medically Necessary orthodontic processes and appliances for treating craniofacial disorders in Covered Persons age eighteen (18) and younger, We will pay benefits as listed in the Schedule of Benefits.

These processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. Coverage is not provided for cosmetic surgery.

Cytology Benefit

Upon receipt of due proof that a Covered Person incurred expenses for an annual cervical cytologic screening, we will pay benefits as listed in the Schedule of Benefits.
We will pay for cytologic screening other than annual only when certified by an attending Physician as Medically Necessary.

This benefit as shown on the Schedule of Benefits is not subject to any Deductible or Coinsurance.

Dental General Anesthesia Benefit

Upon receipt of due proof that a Covered Person incurred expenses for general anesthesia, nursing and related Hospital services provided in conjunction with inpatient, outpatient or one-day dental services if deemed Medically Necessary by the treating dentist or oral surgeon and the Covered Person's primary care Physician, and the Covered Person is either:

1) determined by a licensed dentist, in conjunction with a licensed Physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital; or
2) a person who has a developmental disability, as determined by a licensed Physician who specializes in primary care, that places the person at serious risk.

The expense of such anesthesia, nursing and related Hospital services shall be deemed a medical expense and shall not be subject to any limits on dental benefits under the Policy.

We will pay benefits as listed in the Schedule of Benefits.

Diabetes Supplies, Equipment And Self-Management Training Benefit

Upon receipt of due proof that a Covered Person incurred expenses for laboratory and diagnostic tests and the Medically Necessary treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes, we will pay benefits as listed in the Schedule of Benefits. Such coverage shall include Medically Necessary equipment, in accordance with the Covered Person's treatment plan, drugs and supplies prescribed by a prescribing Physician.

Covered Expenses also include outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. Outpatient self-management training

includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of the professional's practice.

Benefits shall cover:
1) initial training visits provided to an Covered Person after the Covered Person is initially diagnosed with diabetes that is Medically Necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, totaling a maximum of ten hours;
2) training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Covered Person's symptoms or condition which requires modification of the Covered Person's program of self-management of diabetes, totaling a maximum of four hours; and
3) training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes totaling a maximum of four hours.

We will pay benefits as listed in the Schedule of Benefits.

Diabetes means a Covered Person with gestational, type I or type II diabetes.

Early Intervention Services Benefit

Upon receipt of due proof that a Covered Person incurred expenses in connection with Medically Necessary Early Intervention Services provided as part of an individualized family service plan pursuant to Connecticut General Statutes section 17a-248e, we will pay benefits as listed in the Schedule of Benefits. Such coverage shall provide:

1) coverage for such services provided by qualified personnel, as defined in Section 17a-248, for a covered Dependent child from birth until the child's third birthday; and
2) a maximum benefit of $3,200 per covered Dependent child per year and an aggregate benefit of $9,600 per covered Dependent child over the total three (3) year period.

The Company will pay the Covered Expenses in the same way as the Company treats Covered Expenses for any other Sickness; except that no payment made under this Benefit shall be applied against any maximum lifetime or annual limits specified in the Policy.

We will pay benefits as listed in the Schedule of Benefits.

Emergency Ambulance Benefit

Upon receipt of due proof that a Covered Person incurred expenses for the Medically Necessary use of an Ambulance, We will pay the Covered Expenses incurred up to the maximum allowable rate established by the Connecticut Department of Public Health.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Transportation by an Air Ambulance is covered when Medically Necessary because of a life threatening Injury or Sickness.

We will pay the Ambulance Service provider directly if such provider has not received payment for such service from any other source.

We will pay benefits as listed in the Schedule of Benefits.

For purposes of this Benefit:

An **Ambulance** is a vehicle designed, equipped and used to transport the sick and injured.

An **Air Ambulance** is a vehicle designed, equipped and used only to transport by air the sick and injured by air.

Ambulance Service is transportation by an Ambulance or an Air Ambulance to a Hospital or between Hospitals.

Hearing Aid Benefit

Upon receipt of due proof that a Covered Dependent Person twelve (12) years of age or younger incurred expenses for hearing aids, We will pay benefits as listed in the Schedule of Benefits. Such hearing aids are considered durable medical equipment under the Policy.

We will pay benefits as listed in the Schedule of Benefits. This benefit is limited to one thousand dollars within a twenty-four-month period.

Home Health Care Benefit

Upon receipt of due proof that a Covered Person has incurred expenses for Home Health Care Services, We will pay benefits as listed in the Schedule of Benefits. Such services must be provided by a licensed Home Health Agency.

We will pay the incurred expenses up to a maximum of {80 visits} in any one calendar year or in any continuous period of 12 months. Except for a home health aide, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aide, shall be considered as one home health visit.

Charges for such services are not subject to the Deductible.

We will pay benefits as listed in the Schedule of Benefits.

For purposes of this Benefit:

Home Health Care means the continued care and treatment of a Covered Person who is under the direct care and supervision of a Physician but only if: (a) continued hospitalization would have been required if Home Health Care were not provided, except in the case of a Covered Person diagnosed by a Physician as terminally ill with a prognosis of 6 months or less to live,; (b) the home health treatment plan is established and approved by a Doctor within 14 days after an inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Insured Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

Home Health Services Consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the

home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Policy if the Insured Person had remained in the Hospital.

Home Health Agency means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Health and Safety Code.

Hypodermic Needles and Syringes Benefit

Upon receipt of due proof that a Covered Person incurred expenses hypodermic needles or syringes prescribed by a Physician for the purpose of administering medications for medical conditions, We will pay a benefit provided such medications are covered under the Policy

We will pay benefits as listed in the Schedule of Benefits.

Infertility Benefit

Upon receipt of due proof that a Covered Person incurred expenses for the diagnosis and treatment of infertility. We will pay the Benefits listed in the Schedule of Benefits. This coverage will include, but is not limited to: ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer.

Benefits, for the above procedures will be paid regardless of the Experimental or Investigational nature of such procedures subject to the following conditions:

1) the Covered Person must have been covered under the Policy for at least 12 months;
2) benefits are payable only until the Covered Person attains age 40;
3) benefits for ovulation induction are limited to a lifetime maximum benefit of four (4) cycles;
4) benefits intrauterine insemination are limited to a lifetime maximum benefit of three (3) cycles;
5) lifetime benefits are limited to a maximum of two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;
6) coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer is limited to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. However We will not deny coverage to any Covered Person who foregoes a particular infertility treatment or procedure if the Covered Person's Physician determines that such treatment or procedure is likely to be unsuccessful;
7) the covered infertility treatment or procedures must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

We will pay the Benefits listed in the Schedule of Benefits.

Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year periods.

Leukemia Treatment Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Medically Necessary treatment of leukemia, We will pay the benefits listed in the Schedule of Benefits, including:

1) outpatient chemotherapy;
2) reconstructive surgery;
3) cost of any non-dental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis;
4) outpatient chemotherapy following surgical procedures in connection with the treatment of tumors;
5) a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, subject to the maximum benefit in the Schedule of Benefits; and
6) the cost of removing any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be Medically Necessary;
7) the cost of orally administered anticancer medications when used to kill or slow the growth of cancerous cell on the same basis as intravenously administered anticancer medications.

We will pay the incurred expenses in the same way as We pay expenses for any other Sickness; except that the Maximum Benefit per Policy Year shall be:

1) $1,000 for the removal of any breast implant;
2) $500 for the surgical removal of tumors;
3) $500 for reconstructive surgery;
4) $500 for outpatient chemotherapy; and
5) $300 for prosthesis, except that for purposes of the surgical removal of breasts due to tumors the Maximum Benefit per Policy Year shall be $300 for each breast removed.

We will pay the Benefits as listed in the Schedule of Benefits.

Lyme Disease Treatment Benefit

Upon receipt of due proof that a Covered Person incurred expenses for medically necessary treatment of Lyme Disease, We will pay benefits as listed in the Schedule of Benefits.

We will pay the incurred expenses for treatment of Lyme Disease the same way we pay expenses for any other Sickness. However, treatment shall consist of not less than thirty (30) days of intravenous antibiotic therapy, sixty (60) days of oral antibiotic therapy, or both. Treatment shall also include any further treatment recommended by a board certified rheumatologist, infectious disease specialist or neurologist licensed in accordance with chapter 370 of the laws of Connecticut or another state or jurisdiction with similar laws.

We will pay the Benefits as shown in the Schedule of Benefits.

Mammography Benefit

Upon receipt of due proof that a Covered Person incurred expenses for mammography exams, We will pay the Benefits as listed in the Schedule of Benefits. The charges must be incurred while the Covered Member is insured for these benefits.

Benefits will be paid for Covered Expenses incurred for the following:
1) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and
2) a mammogram every year for any woman who is forty years of age or older.

Coverage includes comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's Physician or advanced practice registered nurse.

We will pay the Benefits as listed in the Schedule of Benefits

Mammogram means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

Maternity Benefit

Upon receipt of due proof that a Covered Person incurred maternity expenses, we will pay benefits as listed in the Schedule of Benefits. Charges for timely Postdelivery Care in the mother's home, provider's office, or health care facility, if mother or newborn is discharged from inpatient care before the expiration of the Maximum hours of inpatient care.

We will pay the Benefits as listed in the Schedule of Benefits

Definitions
For the purposes of this benefit the following definition has been added:

POSTDELIVERY CARE means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. It includes parent education, assistance with training in breast feeding and bottle feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care is determined in accordance with recognized medical standards for that care.

Medical Complication of Alcoholism Treatment Benefit

Upon receipt of due proof that a Covered Person incurred expenses for a Hospital confinement in connection with Medical Complications of Alcoholism pursuant to diagnosis or recommendation by a Physician appropriately licensed to treat such condition. We will pay benefits as listed in the Schedule of Benefits

We will pay the Benefits as listed in the Schedule of Benefits

Medical Complications of Alcoholism means such diseases as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens

Medical Foods Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Amino Acid Modified Preparations and Low Protein Modified Food Products for the Medically Necessary treatment of Inherited Metabolic Diseases., We will pay the Benefits as listed in the Schedule of Benefits. The Amino Acid Modified Preparations or Low Protein Modified Food Products must be prescribed for the therapeutic treatment of Inherited Metabolic Diseases and administered under the direction of a Physician. Also covered are charges for Specialized Formulas when such Specialized Formulas are Medically Necessary for a disease or condition and are administered under the direction of a Physician.

We will pay the Benefits as listed in the Schedule of Benefits

Inherited Metabolic Disease means a disease for which newborn screening is required under section 19a-55 and includes cystic fibrosis.

Low Protein Modified Food Product means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Amino Acid Modified Preparation means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Specialized Formula means a nutritional formula for children up to age 12 that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the FDA and is intended for use solely under medical supervision in the dietary management of specific diseases.

Mental and Nervous Conditions Expense Benefit, Including Alcohol Dependency and Substance Abuse

Upon receipt of due proof that a Covered Person incurred expenses for diagnosis and treatment deemed necessary under generally accepted medical standards for treatment of Mental or Nervous Conditions, We will pay the Benefits as listed in the Schedule of Benefits. We will cover Mental or Nervous Conditions as any other Sickness as follows:

1) In the case of benefits payable for the services of a Physician who is an MD, such benefits shall be payable for the same services when such services are lawfully rendered by a licensed psychologist licensed or by such a licensed psychologist in a licensed hospital or clinic.
2) In the case of benefits payable for the services of a Doctor or psychologist, such benefits shall be payable for the same services when such services are rendered by:
   a) a clinical social worker who is Connecticut licensed and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least two thousand hours of post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue

code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

b) a social worker who was certified as an independent social worker in Connecticut prior to October 1, 1990;
c) a licensed marital and family therapist who has completed at least two thousand hours of post-master's marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;
d) a marital and family therapist who was certified in Connecticut prior to October 1, 1992;
e) a Connecticut licensed alcohol and drug counselor or a Connecticut certified alcohol and drug counselor; or
f) a licensed professional counselor.

3) In the case of benefits payable for the services of a Physician who is an MD or a licensed psychologist under section 2) of this benefit, such benefits shall be payable for:
   a) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, Physician, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under items a) to f) inclusive, of subsection 2) above of this benefit;
   b) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under item e) of subsection 2) above of this benefit; or
   c) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under item f) of subsection 2) above of this benefit.
4) In the case of benefits payable for the service of a Physician practicing as a psychiatrist or a licensed psychologist, under section 2) of this benefit, such benefits shall be payable for outpatient services rendered:
   a) in a nonprofit community mental health center, as defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility;
   b) under the supervision of a Physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, or a licensed professional counselor who is eligible for reimbursement under items a) to f) inclusive, of subsection 2) of this benefit; and
   c) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

We will pay Benefits as listed in the Schedule of Benefits.

Mental or Nervous Conditions means those conditions listed in the standard nomenclature of the American Psychiatric Association. Mental or Nervous Conditions include alcohol dependency and substance abuse but do not include:

1) mental retardation;
2) learning disorders;
3) motor skills disorders;
4) communication disorders;
5) caffeine-related disorders;

6) relational problems; and
7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", including autism spectrum disorder.

Neuropsychological Testing Benefit

Upon receipt of due proof that a Covered Dependent under the age of eighteen (18) years diagnosed with Cancer has incurred expenses for neuropsychological testing ordered by a Physician, We will pay the Benefits listed in the Schedule of Benefits. The purpose of such testing must be to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

We will pay Benefits as listed in the Schedule of Benefits.

Ostomy Appliances and Supplies Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Medically Necessary appliances and supplies relating to an ostomy, including but not limited to: collection devices; irrigation equipment and supplies; skin barriers; and skin protectors., we will pay benefits as listed in the Schedule of Benefits.

We will pay the incurred Expenses in the same way as any other Sickness except that the Policy Year Maximum will be limited to [$1000]. Payments under this benefit shall not be applied to any policy maximums for durable medical equipment.

We will pay Benefits as listed in the Schedule of Benefits.

Ostomy includes colostomy, ileostomy and urostomy.

Pain Management Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Pain treatment ordered by a pain management Specialist, We will pay the benefits listed in the Schedule of Benefits. Pain Management Benefits may include all Medically Necessary means to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

We will pay Benefits as listed in the Schedule of Benefits.

Pain means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves.

Pain Management Specialist means a Physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

Post-Mastectomy or Lymph Node Dissection Benefit

Upon receipt of due proof that a Covered Person incurred expenses for post-mastectomy or lymph node dissection charges, We will pay benefits as listed in the Schedule of Benefits.

Covered expenses include:

1) inpatient coverage following a mastectomy or lymph node dissection for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence; and
2) a post-discharge Physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

We will pay Benefits as listed in the Schedule of Benefits.

Prostate Cancer Screening Benefit

Upon receipt of due proof that a Covered Person incurred expenses for prostate cancer screening, we will pay benefits as listed in the Schedule of Benefits for a Covered Person age fifty and over or a Covered Person age forty and over who is at a high risk for prostate cancer, for the screening and diagnosis of prostate cancer, including but not limited to, one prostate-specific antigen testing in a twelve-month period and digital rectal examinations, when Medically Necessary, and consistent with good professional practice.

Well Child Care Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Well Child Care provided to a child through the age of six (6), we will pay benefits as listed in the Schedule of Benefits.

We will pay benefits the same as any other sickness ; except that, no deductible will apply to this benefit.

We will pay Benefits as listed in the Schedule of Benefits.

Well Child Care includes physical examinations, immunizations, history measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment at the following intervals:
1) every two months from birth to six (6) months of age;
2) every three (3) months from nine (9) to eighteen months of age; and
3) annually from two (2) through six (6) years of age.

Wound Care Expense Benefit

Upon receipt of due proof that a Covered Person incurred Covered Medical Expenses for wound-care supplies, We will pay benefits that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician.

We will pay Benefits as listed in the Schedule of Benefits.

CONDITIONAL MANDATED BENEFITS

Off-Label Cancer Drug Use Benefit

Upon receipt of due proof that a Covered Person incurred expenses for off-label use of a federal Food and Drug Administration approved drug and the reasonable cost of supplies Medically Necessary to administer the drug, We will pay benefits as listed in the Schedule of Benefits provided that:

1) the drug is prescribed by a Physician;
2) it is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:
   a) the American Medical Association Drug Evaluations (AMA DE);
   b) the American Society of Hospital Pharmacist's American Hospital Formulary Service Drug Information (AHFS-DI);
   c) the United States Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); or
   d) it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

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

We will pay Benefits as listed in the Schedule of Benefits.

ADDITIONAL BENEFITS

Assistant Surgeon Benefit

Upon receipt of due proof that a Covered Person incurred expenses for surgical assistance by a legally qualified Physician or surgical assistant, not employed by the University's Student Health Center or by the Hospital where the surgery is performed, we will pay benefits as listed in the Schedule of Benefits when such surgical assistance is required by the attending Physician as being Medically Necessary.

Attending Physician Benefit

Upon receipt of due proof that a Covered Person incurred expenses for visits by one or more Physicians while Hospital Confined, we will pay benefits as listed in the Schedule of Benefits. This will not include charges for surgery, obstetrics, or post-operative care.

Dental Injury Expenses Benefit

Upon receipt of due proof that a Covered Person incurred expenses to sound natural teeth as a result of Injury or in the course of treatment for impacted and/or infected wisdom teeth, we will pay benefits as listed in the Schedule of Benefits.

Exclusions
The following exclusion is in addition to any exclusion found in this Policy.

Expenses incurred due to biting or chewing will not be covered under this Policy.

Diagnostic Benefit (when not Hospital Confined)

Upon receipt of due proof that a Covered Person incurred expenses for a Diagnostic Procedure, we will pay benefits as listed in the Schedule of Benefits.

Definitions
For the purposes of this benefit the following definition has been added:

DIAGNOSTIC PROCEDURE means a clinical test or examination. Such procedures include, but are not limited to mammograms, CAT scans, blood analysis, cystoscopy, colonoscopy, endoscopy and X-rays. The Diagnostic Procedure must be performed by a Physician or a medical technician under the direction and supervision of a Physician. The Diagnostic Procedure does not include X-ray, radium, cobalt or chemotherapy treatments administered for the cure or control of Sickness or Injury.

Durable Medical Equipment Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Orthopedic Appliances or as a result of the rental or purchase of Durable Medical Equipment, we will pay the Allowable Charges not to exceed the Maximum Benefit shown on the Schedule. We will not pay a benefit for equipment used in a Hospital.

Definitions
For the purposes of this benefit the following definitions have been added:

DURABLE MEDICAL EQUIPMENT means equipment which is prescribed by a Physician to be used in the home of the Covered Person and which provides for their continued care and treatment. This equipment includes but is not limited to: walkers, crutches, canes, wheelchairs, lavatory chairs, Hospital beds.

ORTHOPEDIC APPLIANCES means braces, artificial limbs or eyes (excluding items of wearing apparel and corrective shoes), and prostheses that require surgical insertion.
Replacement braces and appliances are not covered.

Elective Abortion Benefit

Upon receipt of due proof that a Covered Person incurred expenses for an elective abortion, we will pay benefits as listed in the Schedule of Benefits.

Definitions
For the purposes of this benefit the following definition has been added:

ELECTIVE ABORTION means the voluntary termination of Pregnancy, in accordance with the state law in which the university is located, which results in the death of the fetus.

Hospital Miscellaneous Expenses Benefit

Provided the Covered Person is eligible to receive benefits under the Basic Medical Expense Coverage provision, we will pay benefits as listed in the Schedule of Benefits. Such charges include but are not limited to use of the operating room, medical supplies, oxygen, radiation treatment, and other items Medically Necessary for the treatment of a Sickness or Injury.

Injections Benefit

Upon receipt of due proof that a Covered Person has incurred expenses in connection with covered injection services, we will pay benefits as listed in the Schedule of Benefits.
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Intensive Care Benefit

Upon receipt of due proof that a Covered Person is Confined in an Intensive Care Unit for the treatment of a Sickness or Injury, we will pay benefits as listed in the Schedule of Benefits.

Definitions
For the purposes of this benefit the following definition has been added:

INTENSIVE CARE UNIT means a facility in a Hospital other than the patient's bedroom or an operating or a recovery room. It must be designated by the Hospital as a department providing the highest level of Intensive Care.

Lab Fees Benefit

Upon receipt of due proof that a Covered Person has incurred expenses in connection with covered lab services, we will pay benefits as listed in the Schedule of Benefits.

Lead Poisoning Benefit

Upon receipt of due proof that a Covered Person incurred expenses for screening for lead poisoning, we will pay benefits as listed in the Schedule of Benefits.
Benefits are subject to such Deductible and Coinsurance amounts as shown on the Schedule of Benefits for Injury and Sickness.

Medical Consultation Benefit

Upon receipt of due proof that a Covered Person incurred expenses for other medical advice or assistance by a legally qualified Physician, not on the staff of the University's Student Health Center, we will pay benefits as listed in the Schedule of Benefits when such other medical advice or assistance is required by the attending Physician as being Medically Necessary.

Medical Evacuation Benefit

Offered for International Students:
Upon receipt of due proof that a Covered Person incurred expenses for Physician ordered emergency medical evacuation, including medically appropriate transportation and Medically Necessary care, or including Physician or Nurse accompaniment en route to the nearest suitable Hospital or a facility operated pursuant to law for the care and treatment of ill or injured persons or to the Covered Person's home country, when the Covered Person is critically ill or Injured and has been Hospital Confined for at least 5 days, and appropriate local care is not available, we will pay benefits as listed in the Schedule of Benefits, subject to the prior approval of the claims administrator for this Policy and the attending Physician.

Payment for this benefit is in lieu of all benefits otherwise payable under this Policy. Insurance for the Covered Person ends upon the evacuation.

MRI Cat Scans Benefit

Upon receipt of due proof that a Covered Person incurred Covered Medical Expenses for MRI Cat Scans, we will pay benefits as listed in the Schedule of Benefits.

Nursing Care Benefit

Upon receipt of due proof that a Covered Person incurred expenses for nursing care while Hospital Confined for the treatment of a Sickness or Injury we will pay benefits as listed in the Schedule of Benefits. Nursing care must be Medically Necessary and prescribed by the attending Physician.

Outpatient Miscellaneous Expense Benefit

Upon receipt of due proof that a Covered Person incurred Covered Medical Expenses for Outpatient treatment at a Hospital, emergency room, Physician's office or clinic, we will pay benefits as listed in the Schedule of Benefits. Hemodialysis procedure is included.

Outpatient Prescription Drugs Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Prescription Drugs while an Outpatient**,** including prescription contraceptive drugs and devices**,** including the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drugs and devices, we will pay benefits as listed in the Schedule of Benefits.

Physical Therapy Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Physical Therapy by a Licensed Therapist while not Hospital Confined, we will pay a benefit benefits as listed in the Schedule of Benefits.

Physician Office Visits Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Physician's Office Visit, we will pay benefits as listed in the Schedule of Benefits.

Physiotherapy Benefit

When an Insured by reason of a covered Injury incurs expenses on an outpatient basis for physiotherapy or similar treatment, including diathermy, ultrasonic, microtherm, manipulation or massage, the Company will pay benefits as listed in the Schedule of Benefits.

Pre-Admission Testing Benefit

Upon receipt of due proof that a Covered Person has incurred expenses in connection with Pre-Admission testing 1-7 days prior to Hospital Confinement, we will pay benefits as listed in the Schedule of Benefits.

Private Duty Nurse Benefit

Upon receipt of due proof that a Covered Person incurred expenses for Private Duty Nurses while Hospital Confined for the treatment of a covered Sickness or Injury we will pay benefits as listed in the Schedule of Benefits.

Definitions

For the purposes of this benefit the following definition has been added:

PRIVATE DUTY NURSE means a Nurse whose services are contracted for while the Covered Person is Hospital Confined and who is not employed by the Hospital. The services of the Private Duty Nurse must be required by a Physician.

Radiology And Chemotherapy Benefit

Upon receipt of due proof that a Covered Person incurred expenses for the cost of radiation, radium, or cobalt treatments, and/or chemotherapy treatments, we will pay benefits as listed in the Schedule of Benefits. The expense of radiation, radium, and cobalt treatments and/or

chemotherapy treatments incurred while Hospital Confined, as an outpatient or in a free standing facility is eligible for this benefit.

Repatriation Expense Benefit

Offered for International Students:
Upon receipt of due proof of a Covered Person's death, we will pay the benefits as listed in the Schedule of Benefits for the preparation of the deceased's body for burial or cremation in the Home Country including the cost of embalming and coffin; and transportation of the deceased's body to his or her Home Country. The benefit payable is not to exceed the Maximum Benefit shown on the Schedule, and is subject to the following condition:

1. Approval of the Claims Administrator of this Policy;
2. Death must occur at least 100 miles away from the Covered Person's city of residence**;**
3. Provided that the Covered Person's death occurred outside the territorial limits of his or her Home Country**;** and
4. Expenses incurred under this coverage have been approved by the Claims Office before the body is prepared for transportation.

Definitions
For the purposes of this benefit the following definitions have been added:

HOME COUNTRY – means a Covered Person's country of regular domicile and is named on the Covered Person's Enrollment Form or as provided by and on file with the University indicated on the Schedule of Benefits.

Payment for this benefit is in addition to any other benefits payable under this Policy.

Scalp Hair Prosthesis Benefit

Upon receipt of due proof that a Covered Person incurred expenses for scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer, subject to a written statement by the treating Physician that the prosthesis is Medically Necessary, we will pay benefits as listed in the Schedule of Benefits. Expenses incurred for wigs due to treatment of Leukemia are paid under that benefit and not this benefit.

Benefits are subject to such Deductible and Coinsurance amounts as shown on the Schedule of Benefits for Injury and Sickness.

Second Surgical Opinion Benefit

Upon receipt of due proof that a Covered Person incurred expenses of a second opinion consultation relating to a surgical procedure, we will pay benefits as listed in the Schedule of Benefitsfor this opinion. This benefit will not exceed the Maximum Benefit shown on the Schedule of Benefits.

Surgical And Anesthesia Benefit

Upon receipt of due proof that a surgical procedure for the treatment of a covered Sickness or Injury is performed on a Covered Person, we will pay benefits as listed in the Schedule of Benefitsfor the procedure, including post-operative attendance, not to exceed the Maximum Benefit shown on the Schedule of Benefits, for each Operative Session.

When more than one surgical procedure is performed in the same Operative Session, the Maximum payment will be made for the most expensive surgical procedure and 50% of all other surgical procedures. When two or more surgical procedures are required, which are performed through the same incision and at the same time or in immediate succession, the Maximum amount payable will be the larger amount payable for any one surgical procedure.

No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession unless all procedures are Medically Necessary for the treatment of a single present Injury or Sickness. This does not include dental surgery.

Upon receipt of due proof that a Covered Person incurred expenses for the services of an Anesthesiologist during an Operative Session, we will pay benefits as listed in the Schedule of Benefits for the Anesthesiologist who is not employed by the Hospital, not to exceed the Maximum Benefit shown on the Schedule of Benefits.

Definitions
For the purposes of this benefit the following definitions have been added:

ANESTHESIOLOGIST means a Physician who specializes in anesthesiology.

OPERATIVE SESSION means the continuous period of time during which surgical procedures are performed for the treatment of the Sickness or Injury, regardless of the number of procedures or the number of surgical incisions.

Tests and Procedures Benefit

Upon receipt of due proof that a Covered Person has incurred expenses in connection with covered tests and procedures, we will pay benefits as listed in the Schedule of Benefits.

EXCLUSIONS

Except as specifically provided under this Policy, benefits will not be paid under this Policy and any attached Rider for any expenses which result from:

1) Expenses incurred as the result of dental treatment, except as specifically provided for in the Schedule of Benefits;
2) Services that are provided normally without charge by the University's health center, infirmary or Hospital, or by any person employed by the University;
3) Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except as required for repair caused by a covered Injury;
4) Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within 24 hours of the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;
5) Elective Surgery or Elective Treatment;
6) Declared or undeclared war;
7) Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;.
8) Injury sustained or Sickness contracted while in the service of the armed forces of any country. When an Insured enters the armed forces, we will refund any unearned pro-rata premium with respect to such person;
9) Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
10) Expenses for preventative medicines, vaccines, or prescription drugs, or injections administered during an outpatient visit, except an injection given by a Physician in private practice who will certify that a Medical Emergency was required for the condition, unless specifically covered elsewhere in this Policy;
11) Alcohol intoxication (Intoxication means that the blood alcohol content meets the legal presumption of intoxication under the law of the state where the accident took place.) This exclusion will only apply to expenses incurred as a direct result of an Injury;
12) The voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Covered Person's Physician (applies only to Injury claims);
13) Expenses incurred as a result of any one four wheeled motor vehicle accident;
14) Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to insured students while taking flight instructions for University credit;
15) Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate,
16) Interscholastic, intramural, or club sport, contest or competition sponsored by the University, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant, in excess of $7,000 under the basic accident plan; and
17) Treatment for mental and emotional disorders, except as specifically stated in the Policy (applies to International students only).

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable in excess of $1,500 for domestic students and $5,000 for international students for the Insured's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Insured was medically diagnosed, treated (including medication), or advised by a Physician within the 180 days immediately prior to his Effective Date of Coverage under this Policy. Routine follow-up care to determine whether a breast cancer has reoccurred in a Covered Person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this provision unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a pre-existing condition.

Covered Medical Expenses resulting from a Pre-existing Condition will not be covered unless:

(1) 180 consecutive days have elapsed during which no medical treatment or advice is given by a Physician for such condition; or
(2) the Insured has been insured under this Policy and the school's prior policies for one continuous year; or
(3) The Insured has been receiving benefits under the school's prior policies and has been continuously insured since the date of accident, Injury, or Sickness, whichever occurs first.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this Policy ceases on the termination date. However, if a Covered Person is Hospital Confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the completion of his Hospital Confinement but not to exceed 31days from the expiration date of coverage or beyond release from the Hospital for that Inpatient Confinement or the Maximum Policy benefit whichever occurs first.

If the Insured is also an Insured under the succeeding Policy issued to the Policyholder, this “Extension of Benefits” provision will not apply.

After the “Extension of Benefits’ provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

The total payments made in respect of the Covered Person for each condition both before and after the termination date will never exceed the Maximum Benefit.

NON-DUPLICATION OF BENEFITS

This Policy provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any Other Valid and Collectible Medical Insurance. If Covered Person is covered by Other Valid and Collectible Medical Insurance, all benefits payable by such insurance will be determined before benefits will be paid by this Policy. This Policy is the second payor to any other insurance having primary status or no coordination or non-duplication of benefits provision.

If the Covered Person is insured under group or blanket insurance which is also excess to other coverage, this Policy pays a Maximum of 50% of the benefits otherwise payable.

Benefits paid by this Policy will not exceed: (1) any applicable Policy Maximums; and (2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Medical Insurance.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are paid to us or our agent on or before the due date.

PREMIUM CHANGES We have the right to change the premium rates on any premium due date. We will provide written notice at least 31 days before the date of change. The premium rates may also be changed at any time the terms of this Policy are changed.

GRACE PERIOD This Policy has a 31 day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the grace period.

UNPAID PREMIUM When a claim is paid for expenses incurred during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER In administering this Policy all Insureds must be treated equally. We will rely on your acts.

CLERICAL ERROR Clerical errors or delays in keeping records for this Policy will not deny insurance which would otherwise have been granted; nor extend insurance which otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES This Policy, your application, and any endorsements or other attachments is the entire contract between you and us. Any statement you or the Insured makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between you and us. No change in this Policy will be effective until it is approved by one of our executive officers. This approval must be noted on or attached to this Policy. No agent or other person has authority to change this Policy or to waive any of its terms.

INCONTESTABILITY After this Policy has been in force for two years, it can only be contested for non-payment of premiums. No statement made by an Insured can be used in a contest after his insurance has been in force for two years during his lifetime. No statement an Insured makes can be used in a contest unless it is in writing and signed by him.

MISSTATEMENT OF AGE If the age of an Insured has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon his correct age.

NONPARTICIPATING This Policy is a nonparticipating Policy; it does not share in our surplus.

RECORDS Sufficient records must be maintained to show the names of all Insureds; the dates they became insured; and any such other information required to administer this Policy.

RIGHT TO TERMINATE You or we may end this Policy at any time by giving written notice to the other party thirty-one (31) days prior to the effective date of termination. You must notify all Insureds of such Policy termination.

WORKERS' COMPENSATION This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Workers' Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice must contain the Insured's name and enough information to identify him. Notice may be mailed to our Claims Administrator.

CLAIM FORMS When we receive notice of claim, the Insured will be sent forms to file proof of loss. If the forms are not sent within 15 days after we receive notice, then the Insured will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason if it is shown that written proof of the loss was given as soon as reasonably possible, but in no event more than one year after the date of loss.

PAYMENT OF CLAIMS Claims for benefits provided by this Policy will be paid as soon as written proof is received.

All benefits are paid directly to the Insured, unless he directs us otherwise. If a benefit is unpaid at his death or if we feel he is not able to give a valid receipt for payment, we may pay an amount up to $1,000 to any relative by blood or marriage who we deem to be equitably entitled. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT TO RECOVERY If payments for claims exceed the Maximum amount payable under any benefit provisions or riders of this Policy, we have the right to recover the excess of such payments.

RIGHT OF SUBROGATION We will be fully and completely subrogated to the rights of a Covered Person against parties who may be liable to provide indemnity or make a contribution with respect to any matter that is the subject of a claim under the Policy to the extent allowed by law.

The Covered Person further agrees to cooperate fully with us in seeking such indemnity or contribution including, where appropriate, when we are instituting proceedings at its own expense against such parties in the name of the Covered Person. The Covered Person further agrees that the Company will have a lien to the extent of benefits provided to the extent allowed by law. Such lien may be filed with the person whose act caused the Injury, the person's agent or a court having jurisdiction in the matter.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have the Insured examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS No legal action may be brought to recover against this Policy within 60 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

If a time limit of this Policy is less than allowed by the laws of the state where the Insured lives, the limit is extended to meet the minimum time allowed by such law.

APPEALS PROCEDURE

Internal Appeals: If a claim is wholly or partially denied based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, a written notice will be sent to the Covered Person containing the reason for the denial. The notice will include a reference to the provision in the Certificate and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments, may be sent within 6 months after notice of denial. In preparing the appeal, the Covered Person, or his or her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under

special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

External Appeals: Any Covered Person, or any provider acting on behalf of a Covered Person with the Covered Person's consent, who has exhausted the internal mechanisms to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the Connecticut commissioner of insurance (commissioner).

To appeal a denial or determination, a Covered Person or any provider acting on behalf of a Covered Person with the Covered Person's consent shall, not later than 60 days after receiving final written notice of the denial or determination from Us, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the required filing fee set and a general release executed by the Covered Person for all medical records pertinent to the appeal. We hall also pay to the commissioner the required filing fee. If the commissioner receives 3 or more appeals of denials or determinations by the same insurance company with respect to the same procedural or diagnostic coding, the Insurance Commissioner may, on said commissioner's own motion, issue an order specifying how We shall make determinations about such procedural or diagnostic coding.

Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to a review entity. Upon receipt of the request for appeal from the commissioner, the review entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if such review entity determines:

1) The individual was or is a Covered Person under the Policy;
2) The benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the Policy;
3) The Covered Person or provider acting on behalf of the Covered Person with the Covered Person's consent has exhausted all internal appeal mechanisms provided above;
4) The Covered Person or provider acting on behalf of the Covered Person with the Covered Person's consent has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully-executed release to obtain any necessary medical records from any other relevant provider and Us.

Upon completion of the preliminary review, the review entity shall immediately notify the Covered Person or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons why the appeal was not accepted for full review.

If accepted for full review:

1) The review entity shall conduct such review in accordance with the regulations adopted by the commissioner, after consultation with the Commissioner of Public Health, in accordance with Connecticut law;
2) the commissioner shall notify Us of the receipt of a request for an external appeal and provide the name of the review entity assigned to such appeal.

Not later than 5 business days after such notification, We shall provide to such review entity by electronic mail, telephone, facsimile or other expeditious method all documents and information that were considered in making the adverse determination that is the subject of such appeal.

Not later than 5 business days after receiving a written request from the commissioner, Covered Person or any provider acting on behalf of a Covered Person with the Covered Person's consent, We shall provide to the commissioner:

1) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service;
2) A copy of the Policy or written certification that the Policy is accessible to the review entity electronically and clear and simple instructions on how to electronically access the Policy.

Failure by Us to provide information within said 5 business-day period shall:

1) Create a presumption on the review entity, solely for purposes of accepting an appeal and conducting the review that the benefit or service is a covered benefit under the Policy except that such presumption shall not be construed as creating or authorizing benefits or services in excess of those that are provided for in the Covered Person's Policy; and
2) Entitle the commissioner to require Us a medical necessity determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

MONUMENTAL LIFE INSURANCE COMPANY
(Herein, "we," "us," "our" or "the Company")
Home Office: 4333 Edgewood Road N.E. Cedar Rapids, Iowa 52499
Administrative Office: 520 Park Avenue, Baltimore, Maryland 21201

SPORTS BENEFIT RIDER

This Rider is a part of the Policy to which it is attached. It is issued in consideration of the payment of any premium.

Upon receipt of due proof that a Covered Person incurs expenses for an Injury or Sickness due to practice or participation in intercollegiate athletics sponsored by the Policyholder, we will pay the Usual and Customary Charges not to exceed the Maximum Benefit shown on the Schedule of Benefits. The benefit paid is in lieu of all other benefits.

COVERED ACTIVITIES

An Insured will be covered for losses described in this Policy which are incurred while the Insured is participating in Covered Activities.

Covered Activities include but are not limited to Policyholder sponsored and supervised events and games and practice sessions of intercollegiate sports provided for in this Policy.

Coverage includes supervised travel to and from such activities and games and practice sessions. This includes traveling to or from the Insured's home, school, or the Covered Activity. The covered travel time includes the period before the Insured's required attendance time and the period after the Insureds dismissal or after the Insured completes any extra duties.

Covered sports: **as specified by the Policyholder**.

No benefits are payable under this Rider for:

(1) Infections, except pyogenic infections caused wholly by a covered Injury;
(2) Cysts, blisters or boils;
(3) Overexertion, heat exhaustion, or fainting;
(4) Hernia, regardless of how caused; and
(5) Artificial aids such as crutches, braces appliances, and artificial limbs.

Benefits are payable in accordance with the Benefits provision of the Policy. This Rider does not waive, alter or extend any provisions or limitations of the Policy except to the extent shown above.

This Rider takes effect and expires concurrently with the Policy to which it is attached, as long as premiums are paid.

MONUMENTAL LIFE INSURANCE COMPANY
Cedar Rapids, Iowa

Secretary **President**

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