PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

TABLE OF CONTENTS

PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

Any termination shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received.

Any termination shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

CERTIFICATE: The Company shall issue to the policyholder for delivery to each Insured Person, a certificate setting forth a statement as to the insurance protection to which the Insured is entitled, to whom the benefits are payable, and a statement as to any Dependent's coverage.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

GRACE PERIOD: The Insured is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the Insured has given the Company written notice of discontinuance in advance of the date of discontinuance. The Insured shall be liable to the Company for the payment of a pro rata premium for the time the policy was in force during such grace period.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss. If the Company has not processed the claim within ten (10) working days of receipt of a paper claim, the Company will send acknowledgement of the date a claim is received or notice of the status of a claim that includes a request for additional information. The Company will acknowledge receipt of an electronic claim within one day of receipt.

Within fifteen (15) days after receipt by the Company of any requested additional information, the Company shall pay the claim or any undisputed part of the claim in accordance with this section or send a notice of receipt and the status of the claim: (i) that denies all or part of the claim and specifies each reason for denial; or (ii) that makes a final request for additional information. Within fifteen (15) days after the Company receives the final additional information, the Company shall pay the claim or any undisputed part of the claim or deny or suspend the claim. If the Company has not paid the claim on or before the forty-fifth day after receipt of due written proof of such loss, the Company shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this section shall be included in any late reimbursement without the necessity for the claimant that filed the original claim to make an additional claim for that interest. The Company may combine interest payments and make payment once the aggregate amount reaches five dollars.

If the Company fails to pay, deny or suspend the claim within forty (40) processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid, denied or suspended, the Company shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. Such penalty shall not accrue for more than thirty (30) days unless the claimant provides a second written or electronic notice on or after the thirty (30) days to the Company that the claim remains unpaid and that penalties are claimed to be due pursuant to this section. Penalties shall cease if the Company pays, denies or suspends the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the Company failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recover. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the Company reasonable attorney fees necessary to the defense.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured. Any other accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured. If any indemnity of this policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. All other benefits of the policy shall be payable to the Insured, unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment**.**

The benefits payable hereunder shall be paid, with or without an assignment from the insured, to public hospitals or clinics for services and supplies provided to an Insured if a proper claim is submitted by the public hospital or clinic. No benefits shall be paid under this section to the public hospital or clinic if such benefits have been paid to the Insured prior to receipt of the claim by the Company. Payment to the public hospital or clinic of benefits pursuant to this section shall discharge the Company from all liability to the Insured to the extent of the benefits so paid. Nothing in this section shall be construed to require payment of benefits for the same services or supplies to both the Insured and the public hospital or clinic.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III
DEFINITIONS

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides 24 hour nursing service by Registered Nurses on duty or call; 5) provides organized facilities for diagnosis and surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

INJURY means accidental bodily injury sustained, directly and independently of all other causes; treated by a Physician within 30 days after the date of accident and while the Insured Person is covered under this policy

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under close observation by trained and qualified personnel whose duties are primarily confined to such part of the hospital. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

1) Placing the Insured's health in significant jeopardy;
2) Serious impairment of bodily functions;
3) Serious dysfunction of any body organ or part;
4) Inadequately controlled pain; or
5) With respect to a pregnant woman who is having contractions:
    a. that there is inadequate time to effect a safe transfer to another Hospital before delivery; or
    b. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

1) Essential for the symptoms and diagnosis or treatment of the Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

OTHER VALID AND COLLECTIBLE INSURANCE means: 1) any group plan, program or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans; or 4) group employer or employee benefit programs.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

TOTALLY DISABLED means a condition of a Named Insured which, because of Injury, renders the Named Insured unable to actively attend class.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

PART IV
COVERED LOSS - TIME LIMITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss: due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 30 days after the date of Injury; and, b) is received within 12 months after date of Injury.

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
COLUMBIA COLLEGE - STUDENT PLAN-INJURY ONLY
2018-1708-8
INJURY ONLY BENEFITS

Maximum Benefit	**$10,000 (For Each Injury)**
Deductible	**$0**
Coinsurance	**75% except as noted below**

This policy provides benefits for Injury sustained by an Insured Person while: 1) actually engaged, as an official representative of the Policyholder, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the Policyholder; or 2) actually being transported as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	Usual and Customary Charges
Intensive Care:	Usual and Customary Charges
Hospital Miscellaneous:	Usual and Customary Charges
Physiotherapy:	Paid under Hospital Miscellaneous
Surgery: Specified surgery based on data provided by FAIR Health, Inc.	Usual and Customary Charges
Assistant Surgeon:	Usual and Customary Charges
Anesthetist:	Usual and Customary Charges
Registered Nurse:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
Pre-admission Testing:	Paid under Hospital Miscellaneous

Outpatient

Surgery: Specified surgery based on data provided by FAIR Health, Inc.	Usual and Customary Charges
Day Surgery Miscellaneous:	Usual and Customary Charges
Assistant Surgeon:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
Physiotherapy:	Usual and Customary Charges
(Review of Medical Necessity will be performed after 12 visits for each Injury.)	
Outpatient Miscellaneous Benefits:	No Benefits
Medical Emergency:	Usual and Customary Charges
Diagnostic X-rays:	Usual and Customary Charges
Laboratory:	Usual and Customary Charges
Tests and Procedures:	Usual and Customary Charges
Injections:	Usual and Customary Charges
Prescription Drugs:	No Benefits

Other

Ambulance:	Usual and Customary Charges
Durable Medical Equipment:	Usual and Customary Charges
Consultant:	Usual and Customary Charges
Dental: (Injury to Sound, Natural Teeth only.)	Usual and Customary Charges

SCHEDULE OF BENEFITS *(Continued)*
MEDICAL EXPENSE BENEFITS
INJURY ONLY BENEFITS

MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

SHC Referral Required: Yes ( ) No (X) **Conversion Permitted:** Yes ( ) No (X)

Pre-Admission Notification: Yes ( ) No (X)

( ) **52 week Benefit Period** or (X) **Extension of Benefits**

Other Insurance: (X) ***Coordination of Benefits** ( ) **Primary Insurance**

*If benefit is designated, see endorsement attached.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

4. **Physiotherapy (Inpatient):** See Schedule of Benefits.

5. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

6. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.

7. **Anesthetist Services:** professional services administered in connection with inpatient surgery.

8. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

9. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.

10. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 7 working days prior to admission.

11. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

12. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

13. **Outpatient Miscellaneous Benefit:** outpatient Hospital and Physician services. Outpatient services payable under this benefit will be designated "Paid under Outpatient Miscellaneous Benefit" in the Schedule of Benefits.

14. **Physician's Visits (Outpatient):** Benefits do not apply when related to surgery or Physiotherapy.

15. **Physiotherapy (Outpatient):** See Schedule of Benefits.

16. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the attending Physician's charges, X-rays, laboratory procedures, injections, the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury.

17. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.

18. **Radiation Therapy (Outpatient):** See Schedule of Benefits.

19. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

20. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.

21. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.

22. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

23. **Ambulance Services:** See Schedule of Benefits.

24. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.

25. **Consultant Physician Fees:** when requested and approved by the attending Physician. Covered Medical Expenses will be paid under this benefit or under the Physician's Visits benefit, but not both on the same day.

26. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

PART VII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Acupuncture;

2. Biofeedback;

3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;

4. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;

5. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

6. Elective Surgery or Elective Treatment;

7. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems;

8. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

9. Health spa or similar facilities; strengthening programs;

10. Hypnosis;

11. Immunizations; preventive medicines or vaccines, except where required for treatment of a covered Injury;

12. Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

13. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

14. Injury sustained while (a) participating in any club or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

15. Investigational services;

16. Organ transplants, including organ donation;

17. Participation in a riot or civil disorder; commission of or attempt to commit a felony;

18. Pre-existing Conditions except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months;

19. Prescription Drugs dispensed or purchased while not Hospital Confined;

20. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in Benefits for Clinical Trial for Cancer Treatment;

21. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury;

22. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

23. Sickness or disease in any form; over-exertion; fainting; or hernia, unless such loss results from an accidental bodily Injury;

24. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;

25. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

26. Sleep disorders;

27. Supplies, except as specifically provided in the policy;

28. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile skiing scuba diving, surfing, roller skating, riding in a rodeo;

29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and

30. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

COORDINATION OF BENEFITS PROVISION

Definitions

(1) **Allowable Expenses:** Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

(2) **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.

(3) **Primary:** The Plan whose benefits must be determined without taking the existence of any other Plan into consideration.

(4) **Secondary:** The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.

(5) **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

Effect on Benefits - If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

This Plan determines its order of benefits using the first of the following rules which applies:

1. If your other Plan does not have Coordination of Benefits, that Plan pays first.

COORDINATION OF BENEFITS PROVISION (Continued)

2. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

3. Dependent Child/Parents Not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

    a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but

    b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

    c. However, if the other Plan does not have the rule described in a. above, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

    a. first, the Plan of the parent with custody of the child;

    b. then, the Plan of the spouse of the parent with the custody of the child; and

    c. finally, the Plan of the parent not having custody of the child.

    d. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

5. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

    a. first, the benefits of a Plan covering the person as an employee, member or subscriber or as that person’s dependent; and

    b. second, the benefits under the continuation coverage.

    c. If the other plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

GRIEVANCE PROCEDURE

The following levels of review are available to Insured Persons or providers who have a complaint or a Grievance.

A **Grievance** means a written complaint submitted by or on behalf of an Insured Person regarding:

- the Company's decisions, policies or actions related to availability, delivery or quality of health care services;
- claims payment, handling or reimbursement for health care services;
- the contractual relationship between an Insured Person and the Company; or
- the outcome of an Adverse Determination.

An **Adverse Determination** means a determination that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, and the requested service is therefore denied, reduced or terminated.

The levels of review include:

Informal Review. An Insured Person may submit an oral complaint to the Company for Informal Review after an event that causes a dispute. The Company must respond to the Insured, his/her designated representative, or the provider in writing within thirty days after receiving the complaint and any additional information requested for the Informal Review. At any time during the Informal Review, the Insured Person may submit a written request for the complaint to be reviewed through the Formal Review Process.

Formal Review. The Formal Review process includes a First Level, Second Level and Expedited Review Process.

First Level Review. An Insured Person or his or her provider, in the event of an Adverse Determination, may submit a written Grievance to the Company for review. The Insured Person will not be allowed to attend, nor have a representative attend, a First Level Review. However, the Insured Person may submit written material for the review.

Upon receipt of a request for First Level Grievance Review, the Company will:

(1) Acknowledge receipt of the Grievance in writing within ten working days;
(2) Conduct a complete investigation of the Grievance within twenty working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty working days after receipt of a Grievance, the Insured shall be notified in writing on or before the twentieth working day and the investigation shall be completed within thirty working days thereafter. The notice shall set forth the reasons for the additional time needed for the investigation;
(3) Within five working days after the investigation is completed, the Company will have someone not involved in the circumstances giving rise to the Grievance or its investigation decide upon the appropriate resolution of the Grievance and notify the Insured in writing of the Company's decision regarding the Grievance and of the right to file an appeal for a Second Level Review. The notice shall explain the resolution of the Grievance and the right to appeal in terms which are clear and specific;
(4) Within fifteen working days after the investigation is completed, notify the person who submitted the Grievance of the Company's resolution of said Grievance.

Second Level Review. The Second Level Review process is available to Insured Persons who are not satisfied with the outcome of the First Level Review. The Insured Person, his/her designated representative, or provider may attend the Second Level Review. Persons reviewing a Second Level Grievance that involves an appeal or a clinical issue will include a provider who has appropriate expertise, other enrollees, representatives of the health carrier that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance, and where the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance. Review by the grievance advisory panel shall follow the same time frames as a First Level Review, except as provided for in an Expedited Review, if applicable. Any decision of the grievance advisory panel shall include notice of the Insured's, the Company's or the Master Policyholder's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

Expedited Review. The Insured Person or his or her representative may request an Expedited Review of a Grievance orally or in writing. This level of review is available only in situations where the timeframes for the Informal Review, First Level Review or Second Level Review would seriously jeopardize the life or health of an Insured Person or would jeopardize the Insured Person's ability to regain maximum function. The Company will orally notify the Insured within seventy-two hours after receiving a request for an Expedited Review of the Company's decision. Written confirmation of its decision will be sent within three working days from the date of such notification.

Insured Persons, his/her designated representative, or a provider may contact the Director of the Missouri Department of Insurance for assistance at any time at 1-800-726-7390 or write to Missouri Department of Insurance, P.O. Box 690, 301 West High Street, Truman Building, Room 630, Jefferson City, Missouri 65102-0690.

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith

POLICY NUMBER: 2019-1708-8

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC1 - 10/31/2019
NOC 1708-8
IC Sports Plan:
1)Adding OP Assistant Surgeon to SOB as payable
2)Removed Exclusion #2 Assistant Surgeon Fees;
3)Added Exclusion #18 (Pre-existing Conditions except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months;)