LOUISIANA TECH UNIVERSITY

INVITATION TO BID ONLY

BIDDER MUST FILL IN COMPANY NAME AND COMPLETE ADDRESS (PRINTED OR TYPED)

RETURN THIS FORM TO:

PURCHASING OFFICE
P.O. Box 3157
208 Keeny Circle, Rm. 408
Ruston, LA 71272

Phone: 318-257-4205
Fax: 318-257-3772

Company Quote # if applicable

PHONE:

FAX:

EMAIL:

BID SUBMISSION DEADLINE: September 4, 2024 @ 2:00PM

BID NUMBER: 50012-578-25

DEPARTMENT: Athletics

PRICE MUST BE FIRM FOR AT LEAST 30 DAYS FROM OPENING DATE

DELIVERY IN ______ DAYS

TERMS

BIDDER AGREES TO COMPLY WITH ALL CONDITIONS BELOW AND ATTACHED TO THIS REQUEST.
Prices are to be complete and the FOB point to be Louisiana Tech University unless otherwise specified.

FAILURE TO SIGN WILL DISQUALIFY BID

Typed or Printed Name ______________________ Authorized Signature/Title ______________________

ITEM:	COMPLETE SPECIFICATIONS	QTY. & UNIT:	UNIT PRICE:	AMOUNT:
	Louisiana Tech University's Athletics Department is now accepting SEALED bids for the following:			
1	**Participant Accident Coverage for Intercollegiate Athletics**			
	IMPORTANT DATES: Deadline for written questions to received in the Office of Purchasing: **August 14, 2024 at 5:00PM** Deadline for answers/addendum to be sent to vendors: **August 21, 2024 at 5:00PM**			
	***A bid bond is REQUIRED for this bid. Bid bond shall be five percent (5%) of $508,011.00. Bid bond MUST be in the same envelope as vendor's bid response to be considered for award.**			
	Bid prices to remain firm for a one (1) year period, September 1, 2024 - August 31, 2025, with the option to renew for two (2) additional one (1) year periods if mutually agreed upon by both parties.			
	****PLEASE SEE THE ATTACHED SPECIFICATIONS****			
	ALL BIDS MUST BE RETURNED TO THE LOUISIANA TECH PURCHASING OFFICE VIA MAIL OR IN PERSON. DO NOT FAX OR EMAIL.			
	For all questions or more information, please contact the Office of Purchasing at 318-257-4205 or purchasing@latech.edu.			

IMPORTANT: If bidding other than requested brand and product number (or style), enclose sufficient literature to determine compliance with specifications. Failure to comply with this request may eliminate your bid from consideration. Any manufacturer's names, trade names, brand names, or catalog numbers used in the specifications are for the purpose of describing and establishing general quality levels. Such references or not intended to be restrictive. Bids will be considered for any brand which meets or exceeds the quality of the specifications listed for any item.

BID Request
Participant Accident Coverage for Intercollegiate Athletics
Louisiana Tech University
Ruston, Louisiana

Objective:
Louisiana Tech University in Ruston, Louisiana, is seeking bids from qualified firms for the purpose of establishing a multi component contract for insurance coverage for its student-athletes. Each individual component can be awarded separately. Component 1: Secondary Insurance for all student-athletes on an aggregate deductible platform. Component 2: International Student-Athlete Health Insurance. The contract period shall be for one (1) year with an option for both parties to renew for two (2) additional years.

Background:
Louisiana Tech University is a state supported university offering degrees at the associates, bachelors and graduate levels. The student population comes from across the United States and roughly 68 foreign countries. Spring 2024 enrollment was 10,469 of which 415 were international students. Of these international students, 40 were student-athletes.

The University has relationships established with local and area medical providers that are not subject to change. Those providers are listed below.

- North Louisiana Orthopaedic Clinic
- Green Clinic
- Farrar Endodontics

Individual Components:
Component 1: Secondary Insurance
The purpose of this component is to establish a contact for claims processing of and for participant accident coverage for intercollegiate athletics using the aggregate-deductible plan, in addition to claims processing of and for non-athletic related expenses that the university wishes to pay for. The non-athletic expenses would not be applied to the aggregate-deductible. The process would generally follow this sequence, a provider billing a student-athletes primary insurance which is processed and payment sent to the healthcare provider, who in turn will forward the balance along with the primary Explanation of Benefits to the selected company. In the event a student-athlete doesn't have primary, the said participant accident coverage will roll up to cover the primary and secondary portions of the bill in question. These claims will be paid from the university's self-funded portion of the plan.

Attachment 1-1: Academic Calendar
Attachment 1-2: Current Policy
Attachment 1-3: Athlete Medical Referral
Attachment 1-4: Claims History by Year
Attachment 1-5: Sports Census

Component 2: International Student-Athlete Health Insurance
Louisiana Tech University currently has a contract in place for international student health coverage, but the current contract does not provide coverage for athletic related injuries for intercollegiate student-athletes. Louisiana Tech University Athletic Department does provide insurance coverage for athletic related injuries to its international student-athletes. Information related to the current contract is available in attachments to this bid. A list of the Attachments and their subject are:

Attachment 2-1: Academic Calendar (Same as Attachment 1-1)
Attachment 2-2: Brochure from current plan
Attachment 2-3: Enrolled students by country for Spring 2024

The contract period shall be for one (1) year with an option for both parties to renew for two (2) additional year one (1) year terms. The total term may not exceed three (3) years.

This bid is being issued to locate polices for the upcoming insurance year that will begin September 1, 2024.

Each component can be awarded separately.

Eligibility & Coverage Period:
Component 1
The contract period shall be for a twelve-month period (Fall, Winter, Spring and Summer Quarters). September 1, 2024-August 31, 2025. The benefit period shall be 104 weeks from the date of injury provided on the accident claim form. The benefit period shall survive the contract if the contract expires or is terminated prior to the conclusion of the benefit period.

Coverage should remain in effect for an applicable week or month even though a student may leave school; school isn't in session or hasn't begun. Intercollegiate student-athletes will traditionally be enrolled as a full-time student during the Fall, Winter, and Spring quarters. However coverage must extended into the Summer quarter/months when the student is engaged in NCAA defined athletic activity. The policy should have no gaps in coverage regardless of the institutions academic calendar.

Component 2
It is the policy of Louisiana Tech University that all students, who meet one of the following conditions, are required to have health insurance coverage while they are engaged in full time educational activities

- They are non-immigrant foreign nationals with valid passports from their home countries
- They have been issued an I-20 Certificate of Eligibility by Louisiana Tech University

- They have been granted F-1 student status by U.S. Citizenship and Immigration Services (USCIS)
- They are registered at Louisiana Tech
- They are exchange visitors (and their dependents) who have been issued a DS 2023 by Louisiana Tech University

Hard waivers will be granted to students who have insurance through their parents, government or other extenuating circumstances. A qualified student under the policy will be covered in any country outside his or her country of citizenship and/ or usual domicile.

The policy could also include F-1 students in the following categories:

- F-1 students on 12 month Optional Practical Training
- F-1 students on 24 month STEM extension work period

The contract period shall be for a twelve month period (Fall, Winter, Spring and Summer Quarters). September 1, 2024 – August 31, 2025.

A person who is eligible for coverage shall become an Insured Certificate Holder on the effective date specified by the Policyholder. Coverage is to be in effect 12 months a year.

Coverage should remain in effect for an applicable quarter even though a student may leave school, unless the insured student enters military service, in which coverage would terminate upon entrance. Intercollegiate student-athletes will traditionally be enrolled as a full-time student during the fall, winter, and spring quarters. However coverage must extended into the summer quarter/when the student is engaged in approved NCAA athletic activity.

Students resigning after the premium is paid will be fully covered for the remainder of the quarter. Should a student resign from the University while a claim is pending, the coverage should continue until payment of the maximum amount applicable or until the student is fully recovered, whichever comes first.

<u>ID Cards and Claims Handling Procedure:</u>

Prior to the start of the effective date of the policy, the Company will provide health insurance identification cards/referral form to give to medical providers prior to rendering services. These cards/referral forms should include the University's name, the name and address of the Company, an insurance policy number and the telephone number of the Company to be accessed by the health care providers.

Prior to the start of the effective date of coverage, the Company will provide claim forms that will be completed by the University sports medicine staff. The Company must agree to make a good faith effort to process completed claim forms quickly and efficiently. The claim form must be simple and easy to complete. The Company must accept bills and statement forms generated by hospitals, clinics and attending physicians as supporting

documentation. The Company must provide a toll-free number and have claims representatives available 24 hours/day, 7 days/week to verify coverage.

Administrative Issues:

The bidder must be a licensed agent/broker in the State of Louisiana for the company represented and must provide evidence of an A or better rating in A.M. Best rating.

The company is encouraged submit a list of multiple other division one universities and colleges to whom the bidder has provided medical insurance. This must also include the length of the service provided.

The company must provide a narrative as to their experiences with medical provider discounts in cities where Conference USA teams reside. These include; Lynchburg, VA, Miami, FL, Murfreesboro, TN, El Paso, TX, Bowling Green, KY, Huntsville, TX, Jacksonville, AL, Las Cruces, NM, Kennesaw, GA.

The company must demonstrate its experience in finding cost savings and negotiating lower rates for medical services such as diagnostic imagining, surgery/hospital expenses and physician fees, etc. The company will provide samples of these negotiated contracts. LA Tech does have some corporate contracts with medical providers in place that will continue to be honored. These cooperate contracts include; Northern Louisiana Medical Center, Green Clinic, Trenton Dental Center, and North Louisiana Orthopaedic Clinic.

The company must provide any special agreements that are in place with specialist surgeons across the country and would these discount agreements be available to LA Tech.

The company must provide a description on how their policy would handle DME and medical services that are standard practice in sports medicine, but deemed "experimental" by commercial insurance companies. Examples of these DME and medical services include; core muscle (sports hernia) repair, compression devices such as Game Ready and Recovery Pump, platelet-rich plasma (PRP) injections, stem cell injections, autologous chondrocyte (carticel) implantation, and fracture healing/bone stimulation devices.

The company (component 1 only) must also provide a quote for the administrative fee to handle sickness and non-athletic related claims and expenses LA Tech wishes to pay at its discretion. Please provide a description of these services and the communication between LA Tech the company and the medical provider.

The company must submit evidence of net worth to be able to meet the requirements of the plan outlined. The company must post a surety bond in an amount sufficient to guarantee payment of all reasonably anticipated claims.

The company will provide at least a quarterly claims report upon request. The report must include amount being claimed by each student-athlete, grand total of amount claimed,

and grand total of payments made, itemized by vendor. Report shall show total premiums received, and the total benefits paid, by quarter and cumulatively for the year. Sample copies of "Claims Report" must accompany the bid.

The company must specifically state the average time a claim is paid to a provider and the claim given a clean claim submittal.

The company must possess a client portal which includes secure communication and file submission. Screen shots of the system must be included and follow the specifications stated below.

- HIPPA compliant system that provides real time claims status.
- Provide electronic EOBs/real time reporting including DOS, check number, check date and amount and additional billing details deemed necessary.
- Ability to communicate via an email encryption system.
- Enforce SSL encryption of all communications. Files must be secure in transit using no less than 128-bit encryption using standard industry protocols.

The company will provide any details of all past or pending litigation or claims filed against the company that would negatively impact the company's performance or LA Tech's reputation under an agreement with LA Tech.

The policy must meet any and all USCIS or State Department requirements that pertain to student visa holders and exchange visitors visa holders, including medical evacuation and repatriation benefits. (Component 2 only)

Payment of Premium:

Component 1:

At the beginning of each fiscal year the company will provide LA Tech an invoice for the administrative fees and policy in addition to an invoice for a set dollar amount for self-funded claims balance. The self-funded balance will be reviewed each quarter to determine if and when additional funding is needed.

The University will remit a check for these balances to the company.

Component 2:

At the beginning of each fiscal year Louisiana Tech University will provide the Company with a list that includes the following, additions and subtractions are permitted between quarterly billing cycles.

- Name of student
- Campus Identification number

The University will remit a premium check quarterly with the list of covered international intercollegiate student-athletes.

Benefit Plans:

Component 1:
The medical plans must contain at least the following provisions:

Accident Medical Expense Benefit	$90,000 (NCAA Requirement)
Aggregate Deductible Amount	TBD based off loss history.
Deductible Amount	$0
Usual, Customary & Reasonable	Yes
Benefit Period	104 weeks (from the date of injury)
Full Excess Benefits	Yes
Accident Death and Dismemberment Indemnity	$10,000
AD&D Aggregate	$500,000
Dental Treatment Due to Covered Injury	No limit to max
Physiotherapy Benefit	No limit to max
DME Benefit	No limit to max
Outpatient Prescriptions Benefit	No limit to max
HMO/PPO Denial Benefit	Yes
Expanded Medical Benefit	Yes
Heart and Circulatory Benefit	Yes
Re-Aggravation of Pre-existing Condition Benefit	Yes
Guests & Recruits Benefit (including Men's & Women's Basketball PSA's)	Yes

Component 2:
The medical plans must contain at least the following provisions

- No overall maximum dollar limit.

Deductible:
There should be a deductible of no more than $1000 per each accident or illness for an Insured Certificate Holder, depending on network benefits.

Medical Benefits:
Subject to the exclusions, limitations, and all other provisions of the policy, benefits are to cover at minimum of $100,000 per accident or illness:

Medical Evacuation Benefits:
The policy will cover, up to a maximum benefit of (no more than) $50,000 charges of air evacuation of the injured or sick Insured Certificate Holder to the individual's home country or country of regular domicile or to another medical facility, provided the air evacuation (a) is upon the recommendation and agreement of the attending licensed physician (b) results from a covered injury or sickness, and (c) does not occur prior to the benefit approval.

Repatriation:

The policy will cover, up to a maximum benefit of $25,000 reasonable expenses which are incurred in connection with the cremation or preparation and transportation of the body of a deceased Insured Certificate Holder to the individual's place of residence in the individual's home county provided the individual's death occurred outside his or her home country.

Intercollegiate Athletics:
The policy will cover, up to a maximum benefit of $10,000 per each athletic related injury during the benefit period.

Pregnancy Benefit:
Covered expenses for pregnancy will be payable on the same basis as covered expenses for any other sickness with respect to an Insured Certificate Holder.

Newborn Infants:
A newborn child of an Insured Certificate Holder will automatically be an Insured Individual from the moment of his/her birth for a period of time as deemed in the policy.

Physiotherapy Expenses:
Covered expenses in connection with physiotherapy which are incurred while not confined in a hospital and which are billed by a doctor or physiotherapist, are permitted to be included.

The physiotherapy benefit per calendar year will be no more than $8,000 per individual policy holder.

Exclusions (ALL):
Submit exclusions as defined by your policy

Terms and Conditions (ALL):
Louisiana Tech University reserves the right to withdraw this ITB at any time and for any reason. Receipt of proposal materials by the University or submission of a proposal to the University confers no rights upon the proposer nor obligates the University in any manner. Louisiana Tech University reserves the right to authenticate any and all information contained in the bid of each respective insurance company. Louisiana Tech University will weight multiple items when awarding the bid such as fixed costs versus the stop loss aggregate to ensure the best overall company is awarded the bid.

A contract, based on this bid, may or may not be awarded. Proposals are to be submitted to:

Louisiana Tech University
Purchasing Department
P.O.Box 3157
208 Keeny Circle, Room 408
Ruston, LA 71272

Inquiries may be submitted to the Office of Purchasing, by email, to purchasing@latech.edu. Questions concerning this bid will no longer be permitted to be submitted after August 14, 2024 at 5:00PM.

Contract Changes (ALL):
No additional changes, enhancements, or modifications to any contact resulting from this ITB shall be made without the prior approval of Louisiana Tech University. Changes to the contract include any change in: compensation; beginning/ ending date of the contract; scope of work; and/or Contractor change through the Assignment of Contact process. Any such changes, once approved, will result in the issuance of an amendment of the contract. Contract changes may only be made after the first year of the contract.

Any changes to the premium rates must be based on loss experience and cannot exceed the changed in the Medical Care portion of the Consumer Price Index. Written notice of intention by the Underwriter to extend the contract for the additional two year period and to adjust premium rates for the next policy year shall be given to the Associate Athletic Director – Internal Operations at Louisiana Tech University by May 1st of that year.

Contact Termination (ALL):
Louisiana Tech University reserves the right to terminate this contract at any time for cause based upon the failure of the Contractor to comply with its terms and/or conditions of the agreement, or failure to fulfill its performance obligations pursuant of the agreement, provided that Louisiana Tech University shall give the Contractor written notice specifying the Contractor's failure. If within thirty days after receipt of such notice, the Contractor has not corrected such failure or, in the case of failure which cannot be corrected in thirty days, begun correction, then the State may, at its option, place the Contractor in default and the Agreement shall terminate on the date specified in such notice.

Remedies for Default (ALL):
Any claim or controversy arising from this contract shall be resolved by the provisions of LSA-R.S. 39:1524 through 1526.

Indemnification (ALL):
The Contractor agrees to indemnify and hold the University harmless from any and all claims, demands, liabilities, lawsuits or damages in any way arising out of or based upon the activities or omissions of the Contractor, under this Agreement, including without limitation claims for refund of fees. The University agrees to indemnify and hold the Contractor harmless from any and all claims, demands, liabilities, lawsuits, or damages in any way arising out of or based upon the activities or omissions of the University's personnel.

Auditors (ALL):

It is hereby agreed that the Legislative Auditor of the University and/or the Office of the Governor, Division of Administration auditors of Louisiana shall have the option of auditing all accounts of Contractor which relate to this contract.

Proposal Submission Requirements (ALL):
One (1) signed original and two (2) copies of the proposal under a sealed cover must be received by 2PM on September 4, 2024. Any proposals received after this date/timw shall be rejected. Proposals should be mailed or delivered to:

Louisiana Tech University
Purchasing Department
P.O.Box 3157
208 Keeny Circle, Room 408
Ruston, LA 71272

The outside cover of the package containing the proposal shall be marked:

Participant Accident Coverage for Intercollegiate Athletics
BID NUMBER: 50012-578-25
Name of Offeror

Response Requirements:

1. Cover Letter- Letter summarizing response signed by an authorized representative of the company.
2. Table of Contents.
3. Company Background- Provide background information on your company, including a statement clarifying whether the Proposer is a sole proprietor, a partnership, a corporation or other legal entity.
4. Plan Description- Provide a description of the proposed plan.
5. Premium- Provide a statement of the premiums for the proposed plan for the coverage period.
6. Exclusions- Describe exclusions as defined by your policy.
7. References- Submit information to document successful and reliable experience and service, including reference information. Each proposer must furnish a list of a minimum of five (5) clients currently begin provided international student and scholar health insurance services.
8. Organizational Chart- Provide an organizational chart showing the staffing and lines of authority for key personnel to be used.
9. Supporting Documents. Documentation not included elsewhere including but not limited to, Power of Attorney certifying agent's authority to bind the Proposer if response is submitted by an agent, a statement that Proposer is authorized to do business in the State of Louisiana and has properly registered to do so.

Price Structure:
Component 1:
Administrative Fee's ___________ (including non-athletic related expenses).
Aggregate Deductible Amount __________.

Component 2:
Premium Rates for students only _____________ /FY quarter.

THIS IS A REQUEST FOR A SEALED BID
INSTRUCTIONS TO BIDDERS

1. Read the entire bid, including all terms and conditions and specifications.

2. Louisiana Tech University is not liable for any cost incurred by the bidders prior to execution of a contract and the issuance of a purchase order. Any bidder who ships or otherwise expends time or money prior to award as defined does so at the bidder's own risk.

3. All bid prices must be typed or written in ink. Any corrections, erasures or other forms of alteration to unit prices should be initialed by the bidder. If the bidder needs to submit a change, question, exception, or modification to any aspect of the bid specifications, terms, conditions, or bidder instructions, must do so in written form submitted to the Louisiana Tech University Purchasing Office prior to the bid opening date. All responses and/or addenda will be officially submitted by the Louisiana Tech University Purchasing Office 72 business hours before the bid opening date. Business hours is defined as University operating hours while the University is open. Unless received as specified above, all bid information will remain unchanged.

4. This bid is to be manually signed in ink.

5. Bid prices shall include all delivery charges paid by the vendor, F.O.B. Destination, unless otherwise provided in the solicitation. Bids requiring deposits, "payment in advance" or "C.O.D" may be rejected. Payment is to be made within 30 days after receipt of properly executed invoice or delivery, whichever is later.

6. Amount of bid bond required: every bid submitted for in excess of fifty thousand dollars shall be accompanied by a bid bond guaranteed by a surety company qualified to do business in the state of Louisiana. The bid bond shall be for five percent of the official bid amount.

7. To assure consideration of your bid, all bids and addenda should be returned in an envelope or package clearly marked with the bid opening date and the bid number; or submitted in the special envelope, if furnished for that purpose.

8. Bids submitted are subject to provisions of the laws of the State of Louisiana including but not limited to L.R.S. 39:1551-1736; Purchasing rules and regulations; executive orders; standard terms and conditions; special conditions; and specifications listed in this solicitation.

9. Important: By signing the bid, the bidder certifies compliance with all instructions to bidders, terms conditions and specifications, and further certifies that this bid is made without collusion or fraud. This bid is to be manually signed in ink by a person authorized to bind the vendor (see no. 27). All bid information shall be in ink or typewritten.

10. Address all inquiries and correspondence to the Louisiana Tech University Office of Purchasing at the address and telephone number listed herein.

11. Bid forms: All written bids, unless otherwise provided for, must be submitted on, and in accordance with, forms provided, and properly signed (see no. 27). Bids submitted in the following manner will not be accepted:

    A. Bid contains no signature indicating intent to be bound;
    B. Bid sent by facsimile equipment;
    C. Bid filled out in pencil; and
    D. Bid not submitted on the designated bid forms.

12. Bids must be received at the address specified in the solicitation prior to bid opening time in order to be considered.

13. Standards of quality – Any product or service bid shall conform to all applicable federal, state, and local laws and regulations, and the specifications contained in the solicitation. If bidding other than the requested brand or product number (or style), enclose sufficient literature to determine compliance with specifications. Failure to comply with this request may eliminate your bid from consideration. Unless otherwise specified in the solicitation document, any manufacturer's name,

trade name, brand name, or catalog number used in the specification is for the purpose of describing the standard of quality, performance, and characteristics desired; and is not intended to limit or restrict competition. Bidder must specify the brand and model name of the product offered in the bid. Bids not specifying brand and model number shall be considered as offering the exact product specified in the solicitation. See bid document for full requirements.

14. New Products: Unless specifically called for in the solicitation documents, all products for purchase must be new, never previously used, and the current model and/or packaging. No remanufactured, demonstrator, used or irregular product will be considered for purchase unless otherwise specified in the solicitation documents. The manufacturer's standard warranty will apply unless otherwise stated in the solicitation.

15. Louisiana Tech University reserves the right to award items separately, grouped or on an all-or-none basis and to reject any or all bids and waive any informalities.

16. This agreement is non-exclusive and shall not in any way preclude Louisiana Tech University from entering into similar agreements and/or arrangements with other vendors or from acquiring similar, equal, or like goods and/or services from other entities or sources.

17. Bid opening: Bidders may attend the bid opening, but no information or opinions concerning the ultimate contract award will be given at the bid opening or during the evaluation process. Bids may be examined within 72 hours after bid opening. Information pertaining to completed files may be secured by visiting the Louisiana Tech University Purchasing Office during normal working hours. Written bid tabulations will not be furnished prior to 72 hours.

18. Prices: Unless otherwise specified by Louisiana Tech University in the solicitation, bid prices must be complete, including transportation prepaid by bidder to destination and firm for acceptance for a minimum of 30 days. If accepted, prices must be firm for the contractual period.

19. Taxes: Vendor is responsible for including all applicable taxes, fees, and tariffs in the bid price. Louisiana Tech University is exempt from all Louisiana state and local sales and use taxes. By accepting an award, resident and non-resident firms acknowledge their responsibility for the payment of all taxes duly accessed by the State of Louisiana and its political subdivisions for which they are liable, including but not limited to: franchise taxes, privilege taxes, sales taxes, use taxes, ad valorem taxes, etc.

20. Contract renewals: In the event that bid specifications include a renewal option, a term contract may be extended for two additional 12-month periods at the same prices, terms, and conditions upon mutual agreement of the State of Louisiana agency and the contractor. In such cases, the total contract term cannot exceed 36 months.

21. Contract cancellation: Louisiana Tech University has the right to cancel any contract, in accordance with purchasing rules and regulations, including but not limited to: (1) failure to deliver within the time specified in the contract; (2) failure of the product or service to meet specifications, conform to sample quality or to be delivered in good condition; (3) misrepresentation by the vendor; (4) fraud, collusion, conspiracy or other unlawful means of obtaining any contract with the University; (5) conflict of contract provisions with constitutional or statutory provisions of state or federal law; (6) any other breach of contract. Louisiana Tech University has the right to cancel any contract for convenience at any time by giving thirty (30) days written notice to the vendor. In such cases, the vendor shall be entitled to payment for complaint deliverables in progress.

22. Applicable law: All contracts shall be construed in accordance with and governed by the laws of the State of Louisiana.

23. In accordance with Executive Order Number JBE 2018-15, effective May 22, 2018, for any contract for $100,000 or more and for any contractor with five or more employees, Contractor, or any Subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this contract, refrain from a boycott of Israel. The State reserves the right to terminate this contract if the Contractor, or any Subcontractor, engages in a boycott of Israel during the term of the contract.

24. The bidder agrees to abide by the requirements of the following as applicable: Title VI of the Civil Rights Act of 1964 and Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, Federal Executive Order 11246 as amended, the Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, the Fair Housing Act of 1968 as amended, and bidder agrees to abide by the requirements of the Americans with Disabilities Act of 1990. Bidder agrees not to discriminate in its employment practices, and will render services under this contract without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, veteran status, political affiliation, disability, or age in any matter relating to employment. Any act of discrimination committed by bidder, or failure to comply with these statutory obligations when applicable shall be grounds for termination of any contract entered into as a result of this solicitation.

25. Special accommodation: Any "qualified individual with a disability" as defined by the Americans with Disabilities Act, who has submitted a bid and desires to attend the bid opening, must notify the Louisiana Tech University Office of Purchasing in writing not later than seven days prior to the bid opening date of their need for special accommodations. If the request cannot be reasonably provided, the individual will be informed prior to the bid opening.

26. Indemnity: Contractor agrees, upon receipt of written notice of a claim or action, to defend the claim or action, or take other appropriate measure, to indemnify, and hold harmless, the state, its officers, its agents and its employees from and against all claims and actions for bodily injury, death or property damages caused by the fault of the contractor, its officers, its agents, or its employees. Contractor is obligated to indemnify only to the extent of the fault of the contractor, its officers, its agents, or its employees. However, the contractor shall have no obligation as set forth above with respect to any claim or action from bodily injury, death or property damages arising out of the fault of the state, its officers, its agents or its employees.

27. Signature authority: Attention: R.S. 39:1594(c) (4) requires evidence of authority to sign and submit bids to the State of Louisiana. You must indicate which of the following apply to the signer of this bid.

    Please circle one:

    1) The signer of this bid is either a corporate officer who is listed on the most current annual report on file with the Secretary of State or a member of a partnership or partnership in commendam as reflected in the most current partnership records on file with the Secretary of State. A copy of the annual report or partnership must be submitted to this office before contract award.

    2) The signer of this bid is a representative of the bidder authorized to submit this bid as evidenced by documents such as Corporate Resolution, Certification as to Corporate Principal, etc. If this applies, a copy of the resolution, certification, or other supportive documents must be attached hereto.

    3) The bidder has filed with the Secretary of State an affidavit or resolution or other acknowledged/authentic document indicating that the signer is authorized to submit bids for public contracts. A copy of the applicable document must be submitted to this office before contract award.

28. In accordance with the provisions of R.S. 39:2182, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid form, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts under the provisions of chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950; professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of Title 39, or the Louisiana Procurement Code under the provisions of Chapter 17 of Title 39.

29. It is agreed that the Legislative Auditor of the State of Louisiana and/or the Office of the Governor, Division of Administration auditors shall have the option of auditing all accounts which relate to this contract.

30. The continuation of this contract is contingent upon the appropriation of funds to fulfill the requirements of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if

such appropriation is reduced by the veto of the Governor or by any means provided in the Appropriations Act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract.

31. Whenever a public entity enters in to a contract in excess of five-thousand dollars ($5,000) for the construction, alteration, or repair of any Public Works, the official representative of the public entity shall reduce the contract to writing and have it signed by the parties. When an emergency as provided in R.S. 38:2212(D) is deemed to exist for the construction, alteration, or repair of any Public Works and the contract for such emergency work is less than fifty-thousand dollars ($50,000), there shall be no requirement to reduce the contract to writing (R.S. 38:2241).

32. For each contract in excess of twenty-five thousand dollars ($25,000) per project, the public entity shall require of the contractor a bond with good, solvent, and sufficient surety in a sum of not less than fifty percent (50%) of the contract price for the payment by the contractor or subcontractor to claimants as defined in R.S. 38:2242. The bond furnished shall be a statutory bond and no modification, omissions, additions in or to the terms of the contract, in the plans or specifications, or in the manner and mode of payment shall in any manner diminish, enlarge, or otherwise modify the obligations of the bond. The bond shall be executed by the contractor with surety or sureties approved by the public entity and shall be recorded with the contract in the office of the recorder of mortgages in the parish where the work is to be done not later than thirty days after the work has begun.

33. For construction projects falling within classifications of 37:2150 the bidder must be fully qualified under any state or local licensing law for contractors in effect at the time and at the location of the work before submitting his bid. In the state of Louisiana, revised statutes 37:2150, et seq. Will be considered, if applicable. The contractor shall be responsible for determining that all of his sub-bidders or prospective subcontractors are duly licensed in accordance with law. On any bid in excess of fifty thousand dollars ($50,000), the Contractor shall certify that he is licensed under R.S. 37:2150-2163 and show his license number on the bid. The bid envelope shall be identified on the outside with the Name of the Project, Bid Number, Bid Time, the Name of the Bidder and the License Number of the Bidder.

34. Prohibited Contractual Arrangements – Per Louisiana R.S. 42:1113.A, no public servant, or member of such a public servant's immediate family, or legal entity in which he has a controlling interest shall bid on or enter into any contract, subcontract, or other transaction that is under the supervision or jurisdiction of the agency of such public servant. See statute for complete law, exclusions, and provisions.

TO: Louisiana Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships

RE: Veteran Initiative – Act 167 of the 2009 Legislative Session

➢ ARE YOU ELIGIBLE FOR PARTICIPATION?

- Are you a veteran-owned small entrepreneurship or a service-connected disabled veteran-owned small entrepreneurship in accordance with documentation from the United States Department of Veteran Affairs or the Louisiana Department of Veteran Affairs?
- Are you a Louisiana domiciled business?
- Do you have less than fifty (50) full-time employees?
- Are your annual gross revenue receipts $5,000,000 or less (for construction) or $3,000,000 for (non-construction) for each of the previous three (3) tax years?

If your answers are yes, your company may be eligible for participation in the Louisiana Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurship Program, also known as the Veteran Initiative.

➢ WHAT IS THE VETERAN INITIATIVE?

The Veteran Initiative, created by LRS 39:2171 through 2179 and LRS 51:931, provides additional opportunities for certified Louisiana-based small entrepreneurships to participate in contracting and procurement with the State. Key features of the programs are:

- This is a goal-oriented program
- It is race and gender neutral
- Participation is restricted to Louisiana-based certified veteran-owned and service-connected disabled veteran-owned small entrepreneurships

The rules governing the implementation of the program are located at http://www.doa.louisiana.gov/osp/se/se.htm.

➢ WHY IS CERTIFICATION IMPORTANT?

Certification is required for the participation in the Veteran Initiative. Under this program, you may be given increased opportunity to participate in Louisiana state contracts. Certain contracts may be awarded to your business without competition. And, certification is one of the methods that the State of Louisiana will utilize as a basis for benchmarking for annualized procurement and contracting goals.

➢ WHAT AGENCY IS RESPONSIBLE FOR CERTIFICATION?

The Louisiana Department of Economic Development (LED) is responsible for certifying Small Entrepreneurships for participation in the program. The (LED) Small Business Certification System may be accessed by https://smallbiz.louisianaeconomicdevelopment.com/Account/Login. For additional information regarding certification, please contact the LED at 800.450.8115 or 225.342.3000.

➢ WHAT IS THE ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS?

The Louisiana Department of Veterans Affairs is responsible for disseminating information on this program and other veterans' benefits to Louisiana veterans. Information on this program and other veterans' benefits can be accessed at www.vetaffairs.al.gov.

The State of Louisiana is committed to the success of this program and encourages your participation.

Louisiana Tech University

Attachment 1-1

Racing Form

[ARCHIVED CATALOG]

Fall Quarter 2024

FALL QUARTER 2024 (TERM 251) - approved May 2022

Aug	28	W	**1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m.**
Sept	2	M	**LABOR DAY: UNIVERSITY CLOSED**
	4	W	**FALL QUARTER 2024 BEGINS**
	4	W	**General Registration/Fee Payment** (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –6:00 pm (KEEH 207 & KEEH 103)
	4	W	Placement Exams
	4	W	**2nd Schedule Purge for students who have not confirmed or paid 6:00 p.m.**
	5	R	**CLASSES BEGIN**
	5	R	Late Registration and Drop/Add begins
	9	M	Late Registration ends: Last day for Drop/Add and "no-grade" drops
	17	T	9th class day, **Census Date**
	20	F	Last day to register for Fall graduation (F, Wk 3)
	27	F	Deadline for completeing "I" grade work from Spring/Summer (F, WK4)
Oct	4	F	Deadline for faculty submission of "I" grade work from Spring/Summer (F, Wk5)
	21	M	Advising beings for currently enrolled students.
	25	F	Last day to drop courses or resign with "W" grades ("F" grades after this date (F, Wk8)
	28	M	Early Web Registration Begins for Winter Quarter 2025 (for students enrolled in Fall Quarter 2024)
	28	M	**Veterans, and Degree Candidate Seniors ≥ 110 hours – Early Registration @ 9:00 am**
	28	M	**Honors Students, Grad Students, & Eligible Athletes – Early Registration @ 2:00 pm**
	29	T	**Seniors ≥ 100 hours – Early Registration @ 9:00 am**

	29	T	**Seniors ≥ 90 hours – Early Registration @ 2:00 pm**
	30	W	**Juniors ≥ 80 hours – Early Registration @ 9:00 am**
	30	W	**Juniors ≥ 71 hours – Early Registration @ 2:00 pm**
	31	R	**Juniors ≥ 60 hours – Early Registration @ 9:00 am**
Nov	1	F	**Sophomores ≥ 49 hours – Early Registration @ 9:00 am**
	1	F	**Sophomores ≥ 41 hours – Early Registration @ 2:00 pm**
	4	M	**Sophomores ≥ 30 hours – Early Registration @ 9:00 am**
	5	T	**Freshmen ≥ 13 hours – Early Registration @ 9:00 am**
	5	T	**Freshmen ≥ 9 hours – Early Registration @ 2:00 pm**
	6	W	**Freshmen ≥ 1 hour – Early Registration @ 9:00 am**
	12	T	Degree candidate grades due on Faculty BOSS @ 3:30 p.m.
	14	R	**LAST DAY OF CLASSES**
	15	F	**1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m.**
	16	S	**Fall Commencement Exercises, Thomas Assembly Center @ 10 a.m.**
	16	S	**Fall 2024 QUARTER ENDS**
	18	M	All other grades due on Faculty BOSS @ 3:30 p.m.
	19	T	Grades "live" on Student BOSS
	28	R	**THANKSGIVING HOLIDAY: UNIVERSITY CLOSED**
	29	F	**THANKSGIVING HOLIDAY: UNIVERSITY CLOSED**

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Winter Quarter 2024-2025

WINTER QUARTER 2024-2025 (TERM 252) - approved May 2022

Nov	15	F	**1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m.**
	28	R	**THANKSGIVING HOLIDAY: UNIVERSITY CLOSED**
	29	F	**THANKSGIVING HOLIDAY: UNIVERSITY CLOSED**
Dec	3	T	**WINTER QUARTER 2025 BEGINS**
	3	T	**General Registration/Fee Payment** (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –6:00 pm (KEEH 207 & KEEH 103)
	3	T	Placement Exams
	3	T	**2nd Schedule Purge for students who have not confirmed or paid 6:00 p.m.**
	4	W	**CLASSES BEGIN**
	4	W	Late Registration and Drop/Add begins
	6	F	Late Registration ends: Last day for Drop/Add and "no-grade" drops
	16	M	9th class day, **Census Date**
	20	F	Last day to register for Winter graduation (F, Wk 3)
	23	M	**CHRISTMAS HOLIDAY BEGINS: UNIVERSITY CLOSED**
Jan	3	F	**CHRISTMAS HOLIDAYS END: UNIVERSITY CLOSED**
	10	F	Deadline for completing "I" grade work for Fall (F, WK4)
	17	F	Deadline for faculty submission of "I" grade work from Fall (F, Wk5)
	20	M	**MLK, Jr. BIRTHDAY OBSERVANCE: UNIVERSITY CLOSED**
Feb	3	M	Advising beings for currently enrolled students.
	7	F	Last day to drop courses or resign with "W" grades ("F" grades after this date (F, Wk8)

	10	M	**Early Web Registration Begins for Spring and Summer Quarter 2025** (for students enrolled in Winter Quarter 2024-2025)
	10	M	**Veterans, and Degree Candidate Seniors ≥ 110 hours – Early Registration @ 9:00 am**
	10	M	**Honors Students, Grad Students, & Eligible Athletes – Early Registration @ 2:00 pm**
	11	T	**Seniors ≥ 100 hours – Early Registration @ 9:00 am**
	11	T	**Seniors ≥ 90 hours – Early Registration @ 2:00 pm**
	12	W	**Juniors ≥ 80 hours – Early Registration @ 9:00 am**
	12	W	**Juniors ≥ 71 hours – Early Registration @ 2:00 pm**
	13	R	**Juniors ≥ 60 hours – Early Registration @ 9:00 am**
	14	F	**Sophomores ≥ 49 hours – Early Registration @ 9:00 am**
	14	F	**Sophomores ≥ 41 hours – Early Registration @ 2:00 pm**
	17	M	**Sophomores ≥ 30 hours – Early Registration @ 9:00 am**
	18	T	**Freshmen ≥ 13 hours – Early Registration @ 9:00 am**
	18	T	**Freshmen ≥ 9 hours – Early Registration @ 2:00 pm**
	19	W	**Freshmen ≥ 1 hour – Early Registration @ 9:00 am**
	25	T	Degree candidate grades due on Faculty BOSS @ 3:30 p.m.
	27	R	**LAST DAY OF CLASSES**
	28	F	**1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m.**
Mar	1	S	**Winter Commencement Exercises, Thomas Assembly Center @ 10 a.m.**
	1	S	**WINTER 2024-2025 (252) QUARTER ENDS**
	3	M	All other grades due on Faculty BOSS @ 3:30 p.m.
	4	T	Grades "live" on Student BOSS

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Spring Quarter 2025

SPRING QUARTER 2025 (TERM 253) - approved May 2022

Feb	28	F	**1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m.**
Mar	11	T	SPRING QUARTER 2025 BEGINS
	11	T	**General Registration/Fee Payment** (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –6:00 pm (KEEH 207 & KEEH 103)
	11	T	Placement Exams
	11	T	**2nd Schedule Purge for students who have not confirmed or paid 6:00 p.m.**
	12	W	CLASSES BEGIN
	12	W	Late Registration and Drop/Add begins
	14	F	Late Registration ends: last day for Drop/Add and "no grades" drops
	24	M	9th class day, **Census Date**
	28	F	Last day to register for Spring graduation (F, Wk 3)
Apr	4	F	Deadline for completing "I" grade work from Winter (F, Wk 4)
	11	F	Deadline for faculty submission of "I" grade work from Winter (F, Wk5)
	18	F	EASTER HOLIDAY: UNIVERSITY CLOSED
	21	M	EASTER HOLIDAY ENDS. **Classes resume @ 5:00 p.m.**
	28	M	Advising begins for currently enrolled students
May	2	F	Last day to drop courses or resign with "W" grades. ("F" grades after this date) (F, Wk 8)
	5	M	**Early Web Registration for Fall Quarter 2025:** (for students enrolled in Spring Quarter 2025).
	5	M	**Veterans, and Degree Candidate Seniors ≥ 110 hours – Early Registration @ 9:00 am**
	5	M	**Honors Students, Grad Students, & Eligible Athletes – Early Registration @ 2:00 pm**

	6	T	Seniors ≥ 100 hours – Early Registration @ 9:00 am
	6	T	Seniors ≥ 90 hours – Early Registration @ 2:00 pm
	7	W	Juniors ≥ 80 hours – Early Registration @ 9:00 am
	7	W	Juniors ≥ 71 hours – Early Registration @ 2:00 pm
	8	R	Juniors ≥ 60 hours – Early Registration @ 9:00 am
	9	F	Sophomores ≥ 49 hours – Early Registration @ 9:00 am
	9	F	Sophomores ≥ 41 hours – Early Registration @ 2:00 pm
	12	M	Sophomores ≥ 30 hours – Early Registration @ 9:00 am
	13	T	Freshmen ≥ 13 hours – Early Registration @ 9:00 am
	13	T	Freshmen ≥ 9 hours – Early Registration @ 2:00 pm
	14	W	Freshmen ≥ 1 hour – Early Registration @ 9:00 am
	20	T	Degree candidate grades due on Faculty BOSS @ 3:30 p.m.
	23	F	LAST DAY OF CLASSES
	23	F	1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m. - Summer
	24	S	Spring Commencement Exercises, Thomas Assembly Center, ceremony time TBA
	24	S	SPRING QUARTER 2025 ENDS
	26	M	MEMORIAL DAY HOLIDAY: UNIVERSITY CLOSED
	28	W	All other grades due on Faculty BOSS @ 3:30 p.m.
	29	R	Grades "live" on Student BOSS

[ARCHIVED CATALOG]

Summer Quarter 2025

SUMMER QUARTER 2025 (TERM 254) - approved May 2022

May	23	F	**1st Schedule Purge for students who have not confirmed or paid: 5:00 p.m.**
	26	M	**MEMORIAL DAY HOLIDAY: UNIVERSITY CLOSED**
Jun	3	T	**SUMMER QUARTER 2025 BEGINS**
	3	T	**General Registration/Fee Payment**
	3	T	Placement Exams
	3	T	**2nd Schedule Purge for students who have not confirmed or paid: 6:00 p.m.**
	4	W	**CLASSES BEGIN:** 12-week and 1st 6-week session (Sections 30-37)
	4	W	Late Registration and Drop/Add begins
	6	F	Late Registration ends: Last day for Drop/Add and "no-grade" drops for 12-week and 1st 6-week session
	13	F	**CLASSES BEGIN:** 1st 3-week session (Sections 38-39)
	16	M	Last day for Drop/Add and "no-grade" drops for 1st 3-week session
	16	M	9th Class day, Census Date
**	**	**	Last day to drop courses or resign with "W" grades ("F" grades after this date) ****See Drop Dates on Online Academic Calendar****
	20	F	Last day to register for Summer graduation (F, Wk 3)
Jul	3	R	**CLASSES END: First 3-week session (Sections 38-39)**
	4	F	**INDEPENDENCE DAY: UNIVERSITY CLOSED**
	9	W	**CLASSES END: First 6-week session (Sections 30-37)**
	11	F	**CLASSES BEGIN:** Second 6-week session (Sections 60-67)
	11	F	**CLASSES BEGIN:** Second 3-week session (Sections 68-69)

	11	F	Late Registration and Drop/Add begins: second 3- and 6-week sessions only
	14	M	Late Registration ends: Last day for Drop/Add and "no-grade" drops for 2nd 3- and 6- week sessions only
	14	M	**3rd Scheduled Purge for Students who have not confirmed or paid (registered for 2nd session only) 4:30 p.m.**
	16	W	Grades for 1st 6-week and 3-week session classes due on Faculty BOSS by 3:30 p.m. (W, Wk7)
	25	F	Last day to drop courses or resign with "W" grades for 12-week session
	31	R	**CLASSES END: Second 3-week session (Sections 38-39)**
Aug	1	F	Last day to drop courses or resign with "W" grades for the 2nd 6-week session
	12	T	Degree candidate grades due on Faculty BOSS @ 3:30 p.m.
	14	R	**CLASSES END: 12-week and second 6-week session**
	18	M	All other grades due on Faculty BOSS @ 3:30 p.m.
	19	T	Grades "live" on Student BOSS
	23	S	Summer Commencement, Thomas Assembly Center @ 10 a.m.
	23	S	Summer Quarter 2025 Ends

Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

GREAT AMERICAN INSURANCE GROUP®
PRIVACY NOTICE
AND
NOTICE OF INSURANCE INFORMATION PRACTICES

Great American Insurance Company
Great American Alliance Insurance Company
Great American Assurance Company
Great American Casualty Insurance Company
Great American Contemporary Insurance Company
Great American E & S Insurance Company
Great American Fidelity Insurance Company
Great American Insurance Company of New York
Great American Lloyd's Insurance Company
Great American Protection Insurance Company
Great American Security Insurance Company
Great American Spirit Insurance Company

American Empire Surplus Lines Insurance Company
American Empire Insurance Company
American Empire Underwriters, Inc.

Crop Managers Insurance Agency, Inc.
Dempsey & Siders Agency, Inc.
Eden Park Insurance Brokers, Inc.
Farmers Crop Insurance Alliance, Inc.
GAI Warranty Company
GAI Warranty Company of Florida
Great American Insurance Agency, Inc.
Great American Lloyd's, Inc.
Great American Professional Risk Insurance Services
High Seas Insurance Agencies
Premier Lease & Loan Services Insurance Agency, Inc.
Premier Lease & Loan Services of Canada, Inc.
Strategic Comp, L.L.C.
Strategic Comp Services, L.L.C.

Attachment
1-2

The members of Great American Insurance Group ("Great American," including those companies listed in this Notice) respect your right to privacy.

We want you to know about our procedures for protecting your privacy and your rights and responsibilities regarding nonpublic personal information (referred to as "data" in this notice) we receive about you. We want you to understand how we gather data about you and how we protect it. The terms of this Notice apply to those individuals who inquire about or obtain insurance from Great American primarily for personal, family or household purposes.

We will provide our customers with a copy of the most recent notice of our privacy policy at least annually and more often if we make any changes affecting their rights under our privacy policy. This Notice applies to current and former customers of Great American.

Great American does not share your data except as allowed by law. As a result, you do not need to take any action under this Notice. If we change our practices in the future, we will advise you. If applicable, we will allow you to "opt-out" of certain sharing.

1. **What kind of data is collected about you?**

   We get most of our data about you directly from you, such as your name, address, social security number, income level and certain other financial data. We collect data that you provide during the insurance application process and by other contact with you by mail and over the phone.

   In some cases we may need additional data or may need to verify data you have given us. In those cases, we may obtain data from outside sources at our own expense. For instance, we may collect data from consumer reporting agencies such as credit worthiness and history or employment history. If you send a written request to the address below, we will inform you of the name and address of any agency we have used to prepare a report on you so that you can contact the agency.

   Once you become our customer, we may collect data related to our experiences and transactions with you. This could include data such as insurance policy coverage, premiums and payment history, and any claims you make under your insurance policy. For example, we will retain data collected by a claims representative and police or fire reports.

   We may also collect data about you from our affiliates regarding their transactions and experiences with you (such as your payment or claims history). We do not currently share other credit-related data, except as allowed or required by law.

   Finally, we may collect data when you visit our website or when you email us. We do not sell this or any other data about you to anyone.

2. **What do we do with data about you?**

   Data about you will be kept in our records. We may disclose data to issue and service policies and settle claims. Generally, we will not disclose data about you to any outside group without your prior authorization. However, we may, as allowed by law, share data that we collect as set forth below.

   We may disclose data to your insurance agent.

   We may disclose data to persons who represent you, including your attorney or trustee.

   We may disclose data to adjusters, appraisers, auditors, investigators and attorneys.

   We may disclose data to those who need the data to perform a business, professional or insurance function for us.

   We may disclose data to other insurance companies, agents or consumer reporting agencies, in

connection with any insurance application, policy or claim involving you.

We may disclose data to medical providers to inform you of a medical condition of which you may not be aware and for claims payment purposes.

We may disclose data to others that conduct research, provided that no individual data may be identified in any research study report.

We may disclose data, other than health data, to others that perform marketing services on our behalf.

We may disclose data to our affiliated companies to market products to you and for other purposes. The law does not allow you to restrict this sharing.

We may disclose data to a court, state insurance department or other government agency pursuant to a summons, court order, search warrant, subpoena, or as otherwise required by law or regulation.

We will only disclose your health data in the following ways:

as allowed or required by law;

with your written consent;

to underwrite or administer your policy, claim or account; or

in a manner as previously disclosed to you by us when we collect your health data.

When we disclose your data to third parties for certain purposes described above, we will require them to use your data only for its intended purpose.

3. **Who has access to your data?**

The only people who have access to your data are those who need it to provide or support the provision of products or services to you. We use a system of passwords and other appropriate physical, electronic and procedural safeguards to protect against unauthorized access to your data. We have educated our employees about this Notice and the importance of customer privacy.

4. **How can you review recorded data about you?**

You have the right to access and inspect most of the data that we collect about you. To access your data please send a written request to the address below stating that you would like to access your data. Either you or your personal representative must sign this request and provide a copy of your driver's license or other valid photo identification. You also have the right to request that we correct any data that you believe is incorrect. To amend your data, please send us a written request, at the address below, stating what data you believe needs correcting. Once again, either you or your personal representative must sign this request. If you submit a request to amend your data, we will investigate. If we agree, we will correct our records. Even if we do not correct the data, you have the right to file with us a written statement of dispute, which we will include, in any future disclosure of the data.

If you have any questions about our privacy policy, please write to us at:

GREAT AMERICAN INSURANCE COMPANY
301 E 4th Street
Cincinnati, Ohio 45202-4201
Attn: Compliance Office - Privacy

Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

(over)

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association, if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) Medicare Part C benefits or Medicare Part D benefits;

(8) certain unallocated annuity contracts (which give rights to group contract holders, not individuals) and certain structured settlement annuity contracts;

(9) Other exceptions and exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Association Law, Louisiana Revised Statutes R.S. 22:2081 *et seq.*

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the Association will not pay more than: $500,000 in health insurance benefits; $250,000 in present value of annuities (including cash surrender and cash withdrawal values); or $300,000 in life insurance death benefits (but not more than $100,000 in cash surrender and cash withdrawal values) - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. Other conditions, requirements or exclusions may apply.

Effective Date: August 1, 2014

Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

GREAT AMERICAN INSURANCE COMPANY

MASTER APPLICATION
FOR BLANKET ACCIDENT INSURANCE

Application is hereby made for a plan of blanket accident insurance based on the following statements and representations:

1. **Identification of Policyholder**
   Name of Applicant (Full Legal Name): Louisiana Tech University
   Address of Applicant: 201 Mayfield Ave
   Ruston, LA 71272

2. **Classes of Eligible Persons**

Class	Description of Class
1	All intercollegiate student athletes, student managers, student trainers and student coaches of the Policyholder.

3. **Covered Activities**

   Class 1: While participating in sponsored or supervised activities; participation in regularly scheduled athletic games or competition or practice sessions for the sports herein; participation in off-season physical conditioning for the sports team; and traveling as part of a group in transportation authorized or arranged by the sponsoring organization.

   Covered Sports – Men's Baseball, Men's and Women's Basketball, Women's Bowling, Men's and Women's Cross Country, Men's Football, Men's Golf, Women's Soccer, Women's Softball, Women's Tennis, Men's and Women's Track & Field, Women's Volleyball.

4. **Benefits**
   Accidental Death and Dismemberment
   Accident Medical Expense Benefits
   Optional Additional Benefits
   Sports Coverage II Hazard

5. **Premiums:**

   It is understood and agreed that the premium shall be **$27,600.**

   Such premiums are due and payable in the following manner:
   Yearly, on or before the Policy Effective Date.

The terms and conditions of the requested plan of insurance may vary in certain states as required by the laws of those states. The terms of the policy when issued will govern. It is agreed the insurance applied for will not become effective unless: a) this application is received and approved by us based on our current rules and requirements; b) the policy is accepted by the applicant; and c) the required premium is paid when due.

The Applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance.

NOTICE: This is a limited benefit policy. It does not provide comprehensive health insurance coverage. It does not satisfy the requirements of minimum essential coverage under the Affordable Care Act.

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

____
Signed for the Policyholder

____
Title

____
Date

____
Signed by Licensed Resident Agent
(Where Required by Law)

Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

GREAT AMERICAN INSURANCE COMPANY

SCHEDULE OF BENEFITS

Policyholder: Louisiana Tech University
Policy Number: ICSE897176-00
Policy Effective Date: 08/01/2023
Policy Termination Date: 08/01/2024

Classes of Eligible Persons

Class	Description of Class
1	All intercollegiate student athletes, student managers, student trainers and student coaches of the Policyholder.

Covered Activities

Class 1: While participating in sponsored or supervised activities; participation in regularly scheduled athletic games or competition or practice sessions for the sports herein; participation in off-season physical conditioning for the sports team; and traveling as part of a group in transportation authorized or arranged by the sponsoring organization.

Covered Sports – Men's Baseball, Men's and Women's Basketball, Women's Bowling, Men's and Women's Cross Country, Men's Football, Men's Golf, Women's Soccer, Women's Softball, Women's Tennis, Men's and Women's Track & Field, Women's Volleyball.

Schedule of Benefits: Coverage

Class 1:

Aggregate Limit

Aggregate Benefit Maximum: $250,000 Maximum Benefit
Applies To: Accidental Death and Accidental Dismemberment Benefits

Accidental Death and Dismemberment Benefits

Principal Sum:

Accidental Death: $10,000 Maximum Benefit
Accidental Dismemberment: $10,000 Maximum Benefit

Incurral Period:

Accidental Death: 365 Days
Accidental Dismemberment: 365 Days

Accident Medical Expense Benefits

Benefit Maximum: $90,000 Maximum Benefit
Dental Maximum: $90,000 per **covered person***
*Expenses incurred for dental services are also subject to the Benefit Maximum for Accidental Medical Expense Benefits shown above.
Diminishing Deductible: $0
Aggregate Deductible: $385,000
Maximum Benefit Period: 104 Weeks from the date of the **covered accident**

Incurral Period:	180 Days
Scope of Coverage:	Full Excess Coverage
Heart and Circulatory Conditions:	100% of **reasonable charges** per **covered accident**
Expanded Sports Coverage:	Paid on same basis as Accident Medical Benefits

Schedule of Affiliates

Eligible Persons associated with any affiliate or subsidiary corporation of the Policyholder as of the Policy Effective Date are covered under the **policy.** Their coverage will begin and end in accordance with the Effective Date of Insurance and Termination Date of Insurance provisions in the **policy.** A list of these affiliates and subsidiaries must be kept on file with the Company.

Newly Acquired Organizations.

The premium shown on the **schedule of benefits** applies only to the Policyholder and any affiliates or subsidiary corporations covered on the Policy Effective Date. However, **eligible persons** associated with organizations acquired by the Policyholder during the Policy Term may be covered based on the following terms: The Policyholder must (1) report to Us within 30 days of the acquisition the name of the newly acquired organization and any underwriting information we may need to calculate the premium; and (2) pay the additional required premium, if applicable.

Schedule of Policy Riders

The following riders are attached to and made part of the **policy's** coverage as of the Policy Effective Date. Each rider is subject to all provisions, limitations and exclusions of the **policy** that are not specifically modified by the rider.

Form Number	Description	Applicability
SDM-526 (Ed. 10/13)	Privacy Notice	Class 1
SDM-889 (Ed. 08/14)	LA LHIGA Disclaimer	Class 1
BSR 5000 (Ed. 01/15)	Master Application for Blanket Accident Insurance	Class 1
BSR 5001 (Ed. 01/15)	Schedule of Benefits	Class 1
BSR 7000 (Ed. 01/15)	Blanket Accident Policy	Class 1
BSR 3032 (Ed. 01/15)	Sports Coverage II Hazard Rider	Class 1
BSR 1050 (Ed. 01/15)	Louisiana Amendatory Endorsement	Class 1
IL 72 68 (Ed. 09/09)	In Witness Clause	Class 1

Premiums:

It is understood and agreed that the premium shall be **$27,600.**

Such premiums are due and payable in the following manner:
Yearly, on or before the Policy Effective Date.

Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

GREAT AMERICAN INSURANCE COMPANY

BLANKET ACCIDENT POLICY

Policyholder:	Louisiana Tech University
Type of Policy:	BLANKET ACCIDENT POLICY
Policy Number:	ICSE897176-00
Policy Effective Date:	08/01/2023
Policy Term:	08/01/2023 – 08/01/2024
State of Delivery:	Louisiana

This **policy** takes effect at 12:01 a.m. standard time on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This **policy** terminates at 11:59 p.m. standard time on the last day of the Policy Term, unless the Policyholder and Great American Insurance Company agree to continue coverage under this **policy** for an additional Policy Term.

The provisions and conditions set forth on the pages herein are a part of this **policy** as fully as if recited over the signatures below.

This **policy** is governed by the laws of the state in which it is delivered.

THIS IS A LIMITED BENEFIT POLICY.
IT PROVIDES BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.
BENEFITS ARE NOT PAID FOR LOSS DUE TO SICKNESS.
PLEASE READ THE POLICY CAREFULLY

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SECTION I - DEFINITIONS

Throughout this **policy**, words and phrases that appear in **bold** have special meanings that can be found in the Definitions Section or in the specific Policy provision where those words appear.

Accident means a sudden, abrupt, and unexpected event.

Benefit Plan means a policy or other benefit or service arrangement for medical or dental care, or providing **accident** or health coverage, under any of the following: 1) individual, group or blanket coverage, whether on an insured or self-funded basis; 2) **hospital** or medical service organizations; 3) health maintenance organizations; 4) labor-management plans; 5) employee benefit organization plans; 6) association plans; or 7) any other "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended.

Coinsurance means the ratio by which **we** and the **covered person** share in the payment of **covered expenses** for **medically necessary** treatment. The percentage **we** pay is stated in the **schedule of benefits**.

Covered Accident means an **accident** that occurs directly and independently of all other causes while coverage is in effect for a **covered person** resulting in a **covered loss** or **injury** under the **policy** for which benefits are payable. The **covered person** must be participating in a **covered activity** or specified hazard, as identified in the **schedule of benefits**, when the **accident** occurs.

Covered Activity means those activities set out in the Covered Activities section of the **schedule of benefits**, with respect to which **covered persons** are provided accident insurance under the **policy**.

Covered Expenses mean expenses actually incurred by or on behalf of a **covered person** for treatment, services or supplies covered by the **policy**. Coverage under the **policy** must remain continuously in effect from the date of the **accident** until the date treatment, services or supplies are received for them to be a covered expense. A **covered expense** is deemed to be incurred on the date such treatment, service or supply that gave rise to the expense or the charge was rendered or obtained.

Covered Loss or **Covered Losses** means an accidental death, dismemberment or other **injury** covered under the **policy**.

Covered Person means an **eligible person**, who enrolls for coverage, if required, and for whom the required premium is paid.

Diminishing Deductible means the dollar amount of **covered expense** that must be incurred as an out-of-pocket expense by each **covered person** for each **injury** before Accident Medical Expense Benefits and/or other optional benefits paid on an expense-incurred basis are payable under this **policy**. A **diminishing deductible** means that Accident Medical Expense Benefits payable under any other health care plan will be used to satisfy or reduce the **deductible** shown on the **schedule of benefits**.

Eligible Person means a person in a Class of Eligible Persons, as shown in the **schedule of benefits**.

Free-Standing Ambulatory Surgical Center or Free-Standing Ambulatory Medical Center means a facility providing ambulatory surgical or medical treatment other than a **hospital**, clinic or **physician's** office. It must be qualified to provide the treatment under the standards set by the state in which it is located.

Hospital means an institution that:
1. Operates as a **hospital** pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons;
2. Provides 24-hour nursing service by registered nurses on duty or call;
3. Has a staff of one or more licensed **physicians** available at all times;
4. Provide organized facilities for diagnosis, treatment and surgery, either:
    a. On its premises; or
    b. In facilities available to it, on a pre-arranged basis;

5. Is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a hospital used as such; and
6. Is not primarily a facility for alcohol, drug or behavioral treatment.

Hospital Confined or **Hospital Confinement** means a stay of 24 or more consecutive hours as a registered resident bed-patient in a **hospital**.

Immediate Family Member means a person who is related to the **covered person** in any of the following ways: **spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Incurral Period means the time period within which the **covered loss** or **covered expense** must be incurred. The length of the **incurral period** will be shown in the **schedule of benefits**. The **incurral period** begins on the date of the **covered accident** causing the **covered loss**.

Injury means bodily **injury** sustained by a **covered person** caused by a **covered accident** that:
1. Occurs while this **policy** is in effect as to the person whose **injury** is the basis of claim;
2. Occurs while the **covered person** is participating in a **covered activity**;
3. Occurs under the circumstances described in a hazard applicable to that person; and
4. Results directly and independently of all other causes in a **covered loss** under a benefit applicable to such hazard. See the **schedule of benefits** for applicability of hazards and benefits.

All injuries sustained by one **covered person** in any one **covered accident**, including all related conditions and recurrent symptoms of the **injuries** are considered a single **injury**.

Maximum Benefit Period means the period of time between the date of the **covered accident** causing the **injury** for which benefits are payable and the date after which no further expenses may be incurred for which Accident Medical Expense Benefits will be paid. The Maximum Benefit Period will be shown on the Schedule of Benefits.

Medically Necessary or **Medical Necessity** means a treatment, service or supply provided to treat an **injury** that is:
1. Appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate treatment of the **injury**;
2. Is commonly accepted as proper care or treatment of the **injury** in accordance with the medical practices of the United States and federal guidelines;
3. Can reasonably be expected to result in or contribute to the improvement of the **injury**; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the **injury** or the quality of the medical care provided.

The fact that a **physician** may prescribe, order, recommend, or approve a treatment, service or supply does not, of itself, make the treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under this **policy**.

Physician means a provider or practitioner who:
1. Is properly licensed or certified to provide care or treatment under the laws of the state where he or she practices;
2. Provides services that are within the scope of his or her license or certificate; and
3. Is neither the **covered person** nor a member of the **covered person's** household or an **immediate family member**.

Policy means the contract issued by **us** to the Policyholder for the benefit of a **covered person**.

Policy Aggregate Deductible means the amount of Covered Expenses that must be incurred by all Covered Persons insured under this **Policy**, within the time period specified, before any benefits become payable. The **Policy Aggregate Deductible** and time period within which **Covered Expenses** must be incurred to satisfy it are shown in the **Schedule of Benefits**. If a **Policy Aggregate Deductible** applies during a policy term and **We** and the **Policyholder** agree via a Renewal Amendment, to continue this policy for another policy term, a new **Policy Aggregate Deductible** will apply during that term.

Reasonable Charge means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Schedule of Benefits means the benefits, benefit amounts, terms, limitations and provisions of coverage selected by the Policyholder which is attached to and made a part of this **policy**.

Spouse means an adult person with whom the **covered person** enters into a marriage, civil union, or comparable relationship in a state or nation in which the marriage, civil union or comparable relationship is sanctioned by law and legally valid at the time it is entered into by the parties.

Terrorism or Terrorist Acts means an activity that:

1. Involves any violent act or any act dangerous to human life and that threatens or causes Injury to persons; and
2. Appears in any way intended to: a) intimidate or coerce a civilian population; b) disrupt any segment of a nation's economy; c) influence the policy of a government by intimidation or coercion; or d) affect the conduct of a government by mass destruction, assassination, kidnapping, or hostage-taking; or e) respond to governmental action or policy. **Terrorism or Terrorist Acts** includes any incident declared to be an act of terrorism by an official, department, or agency that has been specifically authorized by federal statute to make such a determination. **Terrorism or Terrorists Acts** shall also include the use of any nuclear weapon or device or the emission, discharge, dispersal, release, or escape of any solid liquid or gaseous chemical or biological agent.

We, Our, Us means Great American Insurance Company or its authorized agent.

SECTION II - POLICY EFFECTIVE AND TERMINATION DATES

Policy Effective Date. The **policy** begins on the Policy Effective Date at 12:01 a.m. standard time at the address of the Policyholder where this **policy** is delivered.

Policy Termination Date. We may terminate this **policy** by giving 31 days advance notice in writing to the Policyholder. This **policy** may be terminated at any time by mutual written consent of the Policyholder and **us.** This **policy** terminates automatically on the earlier of: 1) the Policy Termination Date shown in the **schedule of benefits**; or 2) the premium due date if premiums are not paid when due. Termination takes effect at 11:59 p.m. standard time at the Policyholder's address on the Policy Termination Date shown in the **schedule of benefits.**

SECTION III - PREMIUM

Premiums. The premiums for this **policy** will be based on the rates currently in effect, the plan and amount of insurance in effect.

Changes in Premium Rates. We may change the premium rates from time to time with at least 31 days advanced written notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, **we** reserve the right to change rates at any time if any of the following events takes place:

1. The terms of the **policy** change.
2. A division, subsidiary, affiliated organization, or eligible class is added or deleted from the **policy**.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects **our** benefit obligation.

If an increase or decrease in rates takes place on a date that is not a premium due date, a pro rata adjustment will apply from the date of the change to the next premium due date.

Payment of Premium. The first premium is due on the Policy Effective Date. After that, premiums will be due at the rates and manner described in the **schedule of benefits** unless **we** agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the **policy** will be canceled as of the premium due date, except as provided in the Grace Period provision.

Grace Period. Unless, not less than 10 days prior to the premium due date, **we** have delivered to the Policyholder or mailed to the last known address shown by **our** written records notice of **our** intention not to renew this **policy** beyond the period for which premium has been accepted, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this **policy** will continue in effect. The **policy** will remain in effect during the grace period. If the required premiums are not paid during the **policy** grace period, insurance will end on the last premium due date on which required premiums were paid. The Policyholder will be liable to **us** for any unpaid premium for the time the **policy** was in effect.

SECTION IV - ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the **schedule of benefits** is eligible to be insured on the Policy Effective Date. **We** maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If **we** discover the eligibility requirements are not met, **our** only obligation is to refund any premium paid for that person.

SECTION V - EFFECTIVE DATE OF INSURANCE

Covered Person's Effective Date. A **covered person's** coverage under this **policy** begins on the latest of:

1. The Policy Effective Date as shown in the **schedule of benefits**;
2. The date the person becomes a member of one of the Classes of Eligible Persons shown in the **schedule of benefits**;
3. If individual enrollment is required, the date written enrollment is received by **us**; or
4. The date on which the first premium payment is received by **us** on or before its due date.

SECTION VI - TERMINATION DATE OF INSURANCE

Covered Person's Termination Date. A **covered person's** coverage under this **policy** ends on the earliest of:

1. The date this **policy** terminates;
2. The premium due date if premiums are not paid when due;
3. The effective date on which the **covered person** requests, in writing, that his or her coverage be terminated;
4. The effective date of any written notice of termination by **us**; or
5. The date the **covered person** ceases to be a member of any eligible class(es) of persons as described in the Classes of Eligible Persons section of the **schedule of benefits**.

SECTION VII - DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the **policy**. Please see the **schedule of benefits** for the applicability of these benefits on a class level.

A. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If **injury** to the **covered person** results in any one of the **covered losses** specified below, within the **incurral period** shown in the **schedule of benefits**, **we** will pay the percentage of the principal sum shown below for that **covered loss**. The principal sum is shown in the **schedule of benefits**. If more than one **covered loss** is sustained by a **covered person** as a result of the same **covered accident**, only one amount, the largest, will be paid.

Covered Loss	Benefit Amount
Life	100% of the Principal Sum
Two or more Members	100% of the Principal Sum
One Member	50% of the Principal Sum
Thumb and Index Finger of the Same Hand	25% of the Principal Sum

When used in this benefit, the following terms mean:

Member means **loss of hand or foot**, **loss of sight**, **loss of speech**, and **loss of hearing**.

Loss of hand or foot means complete **severance** through or above the wrist or ankle joint.

Loss of sight means the total, permanent **loss of sight** of one eye.

Loss of speech means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means.

Loss of hearing means total and permanent **loss of hearing** in both ears that is irrecoverable and cannot be corrected by any means.

Loss of a thumb and index finger of the same hand means complete **severance** through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

B. ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay Accident Medical Expense Benefits for **covered expenses** that result directly, and from no other cause, from a **covered accident.**

Accident Medical Expense Benefits are only payable:

1. For **reasonable charges**, incurred after the **deductible** has been met;
2. For **medically necessary covered expenses** that the **covered person** incurs;
3. For charges incurred within 104 weeks after the date of the **covered accident**;
4. Provided the first **covered expense** is incurred within 180 days after the date of the **covered accident** and;

5. Subject to the **Deductibles, Coinsurance,** Rates, **Maximum Benefit Periods**, Benefit Maximums and other terms or limits shown in the **schedule of benefits.**

No benefits will be paid for any expenses incurred that are in excess of **reasonable charges.**

Expanded Sports Coverage: We will also pay Accident Medical Expense Benefits for sports-related conditions, including: (a) overuse syndromes, such as bursitis, tendonitis, shin splints, stress fractures; (b) heat-related problems including heat exhaustion, heat stroke and heat prostration; (c) malfunctions of the heart; (d) embolism; (e) re-injuries (any **injury** for which services have been provided within 365 days from the date of the original **injury** or aggravation thereof); and (f) sprains, hernia, strains, muscle tears, or repetitive motion **injury** (only if these conditions are aggravated by participation in a **covered activity**). Benefits are subject to the **Deductibles, Coinsurance,** Rates, **Maximum Benefit Periods**, Benefit Maximums and other terms or limits shown in the schedule of benefits.

Covered Expenses

1. **Hospital** Room and Board Expenses: the daily room rate when a **covered person** is **hospital confined** and general nursing care is provided and charged for by the **hospital.** In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.

2. Ancillary **Hospital** Expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **hospital confined.**

3. Daily Intensive Care Unit Expenses: the daily room rate when a **covered person** is **hospital confined** in a bed in the intensive care unit and nursing services other than private duty nursing services.

4. Registered Nurse Services while a **covered person** is **hospital confined**; these services must be ordered by a **physician.**

5. Emergency Care (room and supplies) Expenses: incurred within 72 hours of an **accident** and including the attending **physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.

6. Diagnostic x-rays, laboratory procedures and tests.

7. **Free-Standing Ambulatory Surgical Center** or **Free-Standing Ambulatory Medical Center** expenses.

8. **Physician** Non-Surgical Treatment/Examination Expenses (excluding medicines) including the **physician's** initial visit, each **medically necessary** follow-up visit and consultation visits when referred by the attending **physician.**

9. **Physician's** Surgical Expenses

10. Anesthesiologist Expenses and administration of anesthesia.

11. Physiotherapy Expenses on an inpatient or outpatient basis limited to one visit per day (as shown in the **schedule of benefits**). Expenses include treatment and office visits connected with such treatment when prescribed by a **physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.

12. Diagnostic Imaging Expenses including Magnetic Resonance Imaging (MRI) and CAT Scan.

13. Dental Expenses including dental x-rays for the repair or treatment of each **injured** tooth that is whole, sound and a natural tooth at the time of the **covered accident.**

14. Ambulance Expenses for transportation from the emergency site to the **hospital.**

15. Rental of durable medical equipment that:
    a. Is primarily and customarily used to serve a medical purpose;
    b. Can withstand repeated use; and
    c. Generally is not useful to a person in the absence of **injury.**

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

16. Prescription Drug Expenses (for **injuries** only) prescribed by a **physician** and administered on an outpatient basis.

17. Medical Services and Supplies: expenses for blood and blood transfusions; oxygen and its administration.

18. Artificial limbs, eyes, or other prosthetic appliances for initial acquisition and fitting. **We** will not pay for repair or replacement of artificial limbs, eyes, or other prosthetic appliances.

19. Heart and Circulatory Conditions: expenses for treatment of: a) heat exhaustion; b) heart attack; c) stroke; and d) burst aneurysm if the condition occurs during a **covered activity.**

SECTION VIII - SCOPE OF COVERAGE

Full Excess Benefits. This **policy** is secondary coverage to all other policies. **We** will pay **covered expenses** only after the **covered person** satisfies any **deductible** and only when the **covered expenses** are in excess of amounts paid or payable under any other **benefit plan. We** pay benefits without regard to any coordination of benefits provisions in any other **benefit plan.** The amount from other **benefit plans** includes any amount to which the **covered person** is entitled, whether or not a claim is made for the benefits.

The Accident Medical Expense benefits otherwise payable under this policy shall be reduced by 50% when:
(a) The coverage under this **policy** is provided on an excess basis; and
(b) Another **benefit plan** providing Accident Medical Expense Benefits to a **covered person** is an HMO, PPO, or similar arrangement for provision of benefits or services; and
(c) The **covered accident** occurs in the geographic area of the HMO, PPO, or similar arrangement for provision of benefits or services; and
(d) The **covered person** does not use the facilities or the HMO, PPO, or similar arrangement for provision of benefits or services.

This limitation shall not apply to emergency treatment required within 24 hours after an **accident** or when the **accident** occurs outside the geographic area served by the HMO, PPO, or similar arrangement for provision of benefits or services.

It is not **our** intent to reduce benefits for any **covered person** if the **covered person** is outside the network area of their HMO, PPO, or similar arrangement for benefits, and no benefits are available. The reduction of benefits is only for those **covered persons** who can use their HMO, PPO, or similar arrangement and have not done so.

HMO means a Health Maintenance Organization which is any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed to and paid in advance to the provider of service.

PPO means a Preferred Provider Organization which offers health care services through specified health care providers who agree to perform services at rates lower than non-preferred providers.

Coordination with Medicare: Accident Medical Expense Benefits will be paid in compliance with the Medicare Secondary Payer Act (42 U.S.C. §1395y) and any other applicable law regulating the coordination of benefits of government health **plans. We** do not intend to shift to Medicare, Medicaid or any other governmental health **plan** with secondary payer status, the responsibility of primary coverage or payment for any **injury** for which benefits are payable under this **policy.**

SECTION IX – EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

We will not pay benefits for any loss or injury that is caused by, or results from:

1. Sickness, disease, mental infirmity, emotional or psychological trauma, or bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
2. Suicide, self-destruction, attempted suicide or self-destruction, or intentional self-inflicted **injury**, while sane or insane;
3. War or any act of war, whether declared or not;
4. Commission of, or attempt to commit, a felony, an assault, or other illegal activity;
5. Commission of or active participation in a riot, insurrection, or civil disturbance;
6. Medical or surgical treatment, diagnostic procedure, administration or anesthesia, or medical mishap or negligence, including malpractice;
7. The **covered person** being legally intoxicated as determined according to the laws of the jurisdiction in which the **injury** occurred;
8. The **covered person** being intoxicated or under the influence of any drugs or narcotics unless administered by or upon the advice of a **physician**;
9. Any poison, chemical compound, gas or fumes voluntarily taken, administered, absorbed, or inhaled by a **covered person**;
10. Any loss arising out of **terrorism or terrorist acts**;
11. **Injury** covered by workers' compensation, employer's liability laws, or similar occupational benefits, or while engaging in activity for monetary gain from sources other than the Policyholder;
12. A **covered accident** that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon **our** receipt of proof of service, **we** will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded, unless it extends beyond 31 days;
13. Travel in, flight in, boarding, or alighting from an aircraft or aerial device or any craft designed to fly above the Earth's surface;
14. Travel in any aircraft owned, leased, or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
15. Travel in or on any on-road and off-road two or three wheeled motorized vehicle not requiring licensing as a motor vehicle including snowmobiles;
16. Travel or activity outside the United States and its territories;
17. Practice or play in any sports activity, including travel to and from the activity and practice, except as specifically provided in the **policy**;
18. An **accident** that results in a cardiovascular **accident** or stroke caused solely and exclusively by exertion, as verified by a **physician**, while the **covered person** participates in a **covered activity**;
19. Aggravation, during a **covered activity**, of an **injury** the **covered person** suffered before participating in that **covered activity**, unless **we** receive a written medical release from the **covered person's physician**;
20. Participation in **covered activities** not sponsored by or under the supervision of the Policyholder, including skiing, ice hockey, or snowmobiling;
21. The **covered person** riding or driving in any kind of race; or
22. Specified extra-hazardous activities, including: parachuting, hang gliding, motorcycling, mountain biking, non-motorized bike racing (BMX), scuba diving, snow or water skiing, mountain climbing, sky diving, amateur racing of any motor vehicle by water or land, piloting any aircraft, bungee jumping, zip lining, base jumping, spelunking, whitewater rafting, surfing, and parasailing.

In addition to the exclusions above, **we** will not pay Accident Medical Expense Benefits for any loss, treatment, or services resulting from, or contributed to, by:

1. Treatment by persons employed or retained by a Policyholder, or by any **immediate family member** or member of the **covered person's** household;
2. Pregnancy, childbirth, or miscarriage;
3. **Elective abortion**, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
4. **Mental and nervous disorders**;
5. Damage to or loss of dentures or bridges, or damage to existing orthodontic equipment (except as specifically covered by the **policy**);
6. Elective or cosmetic surgery, except for reconstructive surgery needed as the result of an **injury**;
7. Eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, examinations or prescriptions for them, or repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices (except as specifically provided in the **policy**;
8. Orthopedic appliances used mainly to protect an **injury**, so the **covered person** can participate in a **covered activity**;
9. Expenses for which the **covered person** would not be responsible for in the absence of this **policy**;
10. Expenses paid or payable under any automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.)
11. Blood, blood plasma, or blood storage, except expenses by a **hospital** for processing or administration of blood;
12. Treatment or service provided by a private duty nurse (except as specifically provided in the **policy**);
13. Replacement of artificial limbs, eyes, or other prosthetic appliances;
14. Routine physicals, check-ups, routine ob-gyn visits, pap smears, or wellness visits;
15. Overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjures or the aggravation thereof, sprains, hernia, strains, muscle tears, or repetitive motion injury, except as specifically provided in the **policy**;
16. Expenses due to an aggravation or re-**injury** of a **pre-existing condition** (except as specifically provided in the **policy**);
17. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration (except as specifically provided in the policy);
18. Repair, replacement, examinations for prescriptions, or the fitting of eyeglasses or contact lenses;
19. Medical expenses and disability for which the **covered person** is entitled to benefits under any Worker's Compensation Act;
20. Chiropractic care (except as specifically provided in the **policy**);
21. Expenses incurred that are in excess of **reasonable charges**, or expenses that are not **medically necessary**; or
22. Dental treatment necessitated by sickness, deterioration or disease, for cosmetic, preventive, diagnostic or orthodontic purposes, or by any reason other than an **injury**.

LIMITATIONS

Limitation. We will not provide coverage or pay benefits under this **policy** to the extent, and only to the extent, that **we** are prohibited from providing coverage or making payment by any type of travel restriction, trade restriction, economic sanction, or embargo imposed by the U.S. government.

This limitation will not apply if the **covered person** has received a license from the U.S. government to engage in the prohibited activity, provided **we** receive a copy of the license.

Aggregate Limit. The maximum amount payable under this **policy** may be reduced if more than one **covered person** suffers a loss as a result of the same **covered accident**, and if amounts are payable for those losses under one or more of the following benefits provided by this **policy**: Accidental Death and Accidental Dismemberment Benefits. The maximum amount payable for all such losses for all **covered persons** under all those benefits combined will not exceed the amount shown as the Aggregate Limit in the **schedule of benefits.** If the combined maximum amount otherwise payable for all **covered persons** must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual maximum amount otherwise payable for each **covered person** for all such losses under all those benefits combined.

SECTION X - CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to **us** within 20 days after a **covered person's** loss, or as soon thereafter as reasonably possible. Notice must be given by or on behalf of the claimant to **us** with information sufficient to identify the **covered person.**

Claim Forms. We will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in this **policy** for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the **covered person's** name, the Policyholder's name and the Policy Number.

Proof of Loss. Written proof of loss must be furnished to **us** within 90 days after the date of the loss. If the loss is one for which this **policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility and of the loss must be furnished at such intervals as **we** may reasonably require. Failure to furnish such proofs within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of a **covered person** will be made to the **covered person's** beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section. If there is no named beneficiary or surviving beneficiary on record with Us, We will pay benefits in equal shares to the first surviving class of the following: (1) Spouse/Domestic Partner, (2) Children, (3) Parents, (4) Brothers and Sisters. If there are no survivors in any of these classes, We will pay the Covered Person's estate.

Upon receipt of due written proof of loss, payments for all other losses will be made to (or on behalf of, if applicable) the **covered person** suffering the loss. If a **covered person** dies before all payments required under this **policy** have been made, then any remaining amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at **our** option, to any relative by blood or connection by marriage of the payee, who, in **our** sole judgment, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

We may pay benefits directly to any **hospital** or person rendering covered services, unless the **covered person** requests otherwise in writing. Such request must be made no later than the time proof of loss is filed. Any payment **we** make in good faith fully discharges **our** liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under this **policy**, other than for loss for which this **policy** provides for periodic payments, will be paid within 30 days after **our** receipt of due written proof of the loss. Subject to **our** receipt of due written proof of loss, all accrued benefits for loss for which this **policy** provides periodic payment will be paid at the expiration of each month during the continuance of the period for which **we** are liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

SECTION XI - GENERAL PROVISIONS

Entire Contract; Changes. This **policy**, together with any schedules, riders, endorsements, amendments, applications, and enrollment forms, if any, make up the entire contract between the Policyholder and **us**. In the absence of fraud, all statements made by the Policyholder or any **covered person** will be considered representations and not warranties. No written statement made by a **covered person** will be used in any contest, unless a copy of the statement is furnished to the **covered person** or his or her beneficiary or personal representative.

No change in this **policy** will be valid, until approved by an officer of Great American Insurance Company. Such approval must be noted on or attached to this **policy** in writing. No agent may change this **policy** or waive any of its provisions.

Incontestability. The validity of this **policy** will not be contested after it has been in effect for 2 years from the Policy Effective Date, except as to nonpayment of premiums.

Beneficiary Designation and Change. The **covered person's** designated beneficiary(ies) is (are) the person(s) so named by the **covered person** and on signed record with the Policyholder.

A legally competent **covered person** over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing **us** or, if agreed upon in advance by **us**, the Policyholder, with a written request for change. When the request is received by **us** or, if agreed upon in advance by **us**, the Policyholder, whether the **covered person** is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but will not apply to or prejudice **us** as respects any payment which may have been made prior to **our** receipt of the request.

Physical Examination and Autopsy. We have the right, at **our** own expense, to examine the **covered person**, when and as often as may be reasonably required during the pendency of a claim. **We** may also require an autopsy of the remains of any **covered person** where it is not prohibited by law.

Legal Actions. No legal action for a claim can be brought against **us** until 60 days after receipt of proof of loss. No legal action for a claim can be brought against **us** more than three years after the time for giving proof of loss.

Noncompliance With Policy Requirements. No express waiver by **us** of any requirement(s) of this **policy** will constitute a continuing waiver of such requirement(s). Any failure by **us** to insist upon compliance with any **policy** provision(s) will not operate as a waiver or amendment of that provision.

Conformity With Statutes. Any provision of this **policy** which, on its effective date, is in conflict with the law of the jurisdiction in which the **policy** was delivered, is hereby amended to conform to the minimum requirements of such law.

Clerical Error. Clerical error, whether by the Policyholder, the **covered person** or **us** in keeping records pertaining to this **policy,** will not:

1. Invalidate coverage otherwise validly in effect; or
2. Continue coverage otherwise validly terminated.

Data Required. The Policyholder must maintain adequate records acceptable to **us** and provide any information required by **us** relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Audit. We will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Non-Duplication of Workers' Compensation Benefits. No benefits will be payable under this **policy** for any loss for which the **covered person** claims coverage under any workers' compensation, employers' liability, occupational disease or similar law. In the event a claim is made under any workers' compensation, employers liability, occupational disease or similar law arising out of the same or substantially same **accident** or **injury**, the **covered person** must immediately reimburse **us** for all benefits paid in conjunction with that **accident** or **injury.**

Right to Receive and Release Needed Information. We have the right to decide in **our** sole judgment what facts **we** need to administer this **policy. We** may get needed facts from, or give them to, any other organization or person. **We** need not tell, or get the consent of, any person to do this. Each person claiming benefits under this **policy** must give **us** any facts **we** need to determine coverage under this **policy** or determine the correct payment of a claim.

Facility of Payment and Right of Recovery. If a payment made under another **plan** includes an amount that should have been paid under this **policy**, **we** may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this **policy**, and **we** will not have to pay that amount again. If the amount of the payments made by **us** is more than it should have paid under this **policy**, **we** may recover the excess from any person(s) to or for whom **we** have overpaid, including insurance companies or other organizations.

Time Limit on Certain Defenses. After two years from the date of issue of this **policy** no misstatements, except fraudulent misstatements, made by an applicant in any application for this **policy** will be used to void this **policy** or to deny a claim for loss incurred or disability, as defined in this **policy**, commencing after the expiration of such two year period.

No claim for loss incurred or disability, as defined in this **policy**, commencing after two years from the date of issue of this **policy** will be reduced or denied on the ground that a condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this **policy**.

Certificates Of Insurance. Where it is required by law, or upon the request of the Policyholder, **we** will make available certificates outlining the insurance coverage, and to whom benefits are payable under the **policy**.

Subrogation. To the extent **we** make a payment under this **policy** and the person to whom or for whose benefit payment has been made has any right to recover from anyone liable for the **covered loss**, **we** may assume the rights of the **covered person** and/or his or her designated beneficiary. **We** will be reimbursed for any payments made to or on behalf of the **covered person** and/or the designated beneficiary, regardless of whether or not the **covered person** or person to whom payment has been made has been made whole. The **covered person** and/or his or her designated beneficiary will do everything necessary to transfer those rights to **us**, will do nothing to prejudice those rights and agrees to assist **us** in preserving **our** subrogation and reimbursement rights.

The **covered person** or designated beneficiary must reimburse **us** for any payments **we** make under this **policy**, to the extent that **covered person** or designated beneficiary receives payment from any party for the same **covered loss**.

Assignment. This **policy** is non-assignable. A **covered person** may assign all of his or her rights, privileges and benefits under this **policy**. **We** are not bound by an assignment, until **we** receive a signed copy. **We** are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of this **policy**. Any payment made in good faith will relieve **us** or **our** liability under the **policy**.

Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

GREAT AMERICAN INSURANCE COMPANY

SPORTS COVERAGE II HAZARD RIDER

This rider is attached to and made part of the **policy** as of the Effective Date shown above. If no Effective Date is shown, this rider takes effect as of the Effective Date shown on the **schedule of benefits.** It is subject to all the provisions, limitations, and exclusions of the **policy**, except as they are otherwise specifically modified by this rider. This rider is applicable only to a **covered person** in a class to which the specific hazard described herein applies, as set forth in the **schedule of benefits**, and only with respect to a **covered accident** that occurs during one of the **covered activities** listed in the **schedule of benefits** on or after the Effective Date and prior to the termination of the **policy.** This rider terminates at the same time as the Policy. Unless otherwise specified, benefits for the hazard described in this rider are paid only once for any one **covered accident.**

Sports Coverage II Hazard Rider. We will pay benefits for the hazard described in this rider if the **covered accident** takes place while:

1. The **covered person** is taking part in a regularly scheduled athletic game or official tournament game; or

2. The **covered person** is taking part in a practice session for an athletic team or club; and

3. The **covered person** is traveling without **personal deviation** or interruption to or from a game or practice session with the athletic team or club in a vehicle operated by a properly licensed driver over the age of 21 who is under the direct supervision of the athletic team or club; and

4. **Travel time** does not exceed two hours each way.

Definitions. When used in this rider, the following terms means:

Personal Deviation - an activity that is not reasonably related to the Policyholder's activities and is not incidental to the purpose of the trip.

Travel Time - travel to or from a scheduled game, official tournament game, or practice session both before the required attendance time and after dismissal including the completion of any extra duties assigned by the Policyholder.

INSURANCE GROUP

Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

GREAT AMERICAN INSURANCE COMPANY

LOUISIANA AMENDATORY ENDORSEMENT

Policy Number: ICSE897176-00 **Effective Date:** 08/01/2023
Policyholder: Louisiana Tech University **Rider #:** 01

This rider is attached to and made part of the **policy** as of the Effective Date shown above. If no Effective Date is shown, this rider takes effect as of the Policy Effective Date shown on the **schedule of benefits.** It is subject to all the provisions, limitations, and exclusions of the **policy**, except as they are otherwise specifically modified by this rider. It applies only with respect to a loss that occurs on or after the Policy Effective Date and prior to the termination of the **policy**. This rider terminates at the same time as the **policy**.

BLANKET ACCIDENT INSURANCE POLICY – BSR 7000 is amended as follows:

POLICY EFFECTIVE AND TERMINATION DATES section is amended as follows:

1. The **Policy Termination Date** provision is hereby deleted and replaced with the following:

   Policy Termination Date. We may terminate this **policy** by giving 60 days advance notice in writing to the Policyholder. The Policyholder may terminate this **policy** on any premium due date by giving advance written notice to **us.** This **policy** may be terminated at any time by mutual written consent of the Policyholder and **us.** This **policy** terminates automatically on the earlier of: 1) the Policy Termination Date shown in the **schedule of benefits**; or 2) the premium due date if premiums are not paid when due. Termination takes effect at 11:59 p.m. standard time at the Policyholder's address on the Policy Termination Date shown in the **schedule of benefits.**

PREMIUM section is amended as follows:

1. The **Changes in Premium Rates** provision is hereby deleted and replaced with the following:

   Changes in Premium Rates. We may change the premium rates from time to time with at least 45 days advanced written notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, **we** reserve the right to change rates at any time if any of the following events takes place:
   1. The terms of the **policy** change.
   2. A division, subsidiary, affiliated organization, or eligible class is added or deleted from the **policy**.
   3. There is a change in the factors bearing on the risk assumed.
   4. Any federal or state law or regulation is amended to the extent it affects **our** benefit obligation.

   If an increase or decrease in rates takes place on a date that is not a premium due date, a pro rata adjustment will apply from the date of the change to the next premium due date.

DESCRIPTION OF BENEFITS section is amended as follows:

1. **Covered expense** item 16. under the **Accident Medical Expense Benefit** is hereby deleted and replaced with the following:

   16. Prescription Drug Expenses (for **injuries** only) prescribed by a **physician** and administered on an outpatient basis. The **covered person** is responsible for the payment of local taxes assessed on prescription drugs.

EXCLUSIONS AND LIMITATIONS section is amended as follows:

1. Exclusion 22. of the exclusions applicable to Accident Medical Expense Benefits is hereby deleted:
   22. Chiropractic care (except as specifically provided in the **policy**);

CLAIM PROVISIONS section is amended as follows:

1. The **Notice of Claim** provision is hereby deleted and replaced with the following:

   Notice of Claim. Written notice of claim must be given to **us** within 20 days after a **covered person's** loss, or as soon thereafter as reasonably possible. Failure to give notice of claim within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give notice within such time, provided such proof is furnished as soon as reasonably possible. Notice must be given by or on behalf of the claimant to **us** with information sufficient to identify the **covered person**.

GENERAL PROVISIONS section is amended as follows:

1. The **Subrogation** provision is hereby deleted and replaced with the following:

   Subrogation. To the extent **we** make a payment under this **policy** and the person to whom or for whose benefit payment has been made has any right to recover from anyone liable for the **covered loss, we** may assume the rights of the **covered person** and/or his or her designated beneficiary. **We** will be reimbursed for any payments made to or on behalf of the **covered person** and/or the designated beneficiary after the **covered person** has been fully compensated. The **covered person** and/or his or her designated beneficiary will do everything necessary to transfer those rights to **us**, will do nothing to prejudice those rights and agrees to assist **us** in preserving **our** subrogation and reimbursement rights. **We** will contribute, as appropriate, to the attorney's fees incurred in obtaining any such payments from the party liable for the **covered loss**.

   The **covered person** or designated beneficiary must reimburse **us** for any payments **we** make under this **policy**, to the extent that **covered person** or designated beneficiary receives payment from any party for the same **covered loss**.

2. The **New Entrants** provision is hereby added:

   New Entrants. All **eligible persons** added to one of the Classes of Eligible Persons in the **schedule of benefits** and any person required to be provided coverage under federal law are eligible for insurance under this **policy**.

This Endorsement is made a part of the Policy and Certificate to which it is attached. All other terms and conditions of the Policy and Certificate remain unchanged.

Administrative Offices
301 E 4th Street
Cincinnati, Ohio 45202-4201
Tel: 1-513-369-5000

In Witness Clause

In Witness Whereof, we have caused this Policy to be executed and attested, and, if required by state law, this Policy shall not be valid unless countersigned by our authorized representative.

President

Secretary

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Attachment 1-3

A MEDICAL REFERRAL IS REQUIRED FOR EACH VISIT

PHYSICIAN

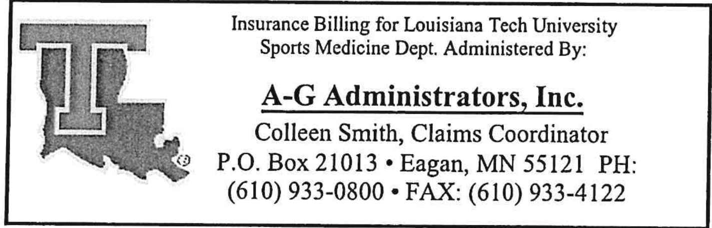
____

DATE _______________

TIME _______________

PROVIDER

- [ ] North LA Sports Med.
- [ ] N. La. Medical Center.
- [ ] Green Clinic Northside
- [ ] Green Clinic -Main
- [ ] Trenton Dental
- [ ]
- [ ] Other



Insurance Billing for Louisiana Tech University Sports Medicine Dept. Administered By:

A-G Administrators, Inc.

Colleen Smith, Claims Coordinator
P.O. Box 21013 • Eagan, MN 55121 PH: (610) 933-0800 • FAX: (610) 933-4122

INSURANCE / BILLING INFORMATION

- [ ] **BILL STUDENT-ATHLETE'S PRIMARY INSURANCE FIRST! IF THE ATHLETE HAS INSURANCE COVERAGE, YOU (THE PROVIDER) MUST FILE WITH THAT INSURANCE FIRST.** Once that insurance has responded to the claim, please send an itemized statement and a copy of the Explanation of Benefits to the address above. The Louisiana Tech University Athletic Department will be financially responsible for the remaining fees and services rendered directly related to the condition for which referral has been made **AFTER** the student-athlete's primary insurance has paid.
- [ ] The Louisiana Tech University Athletic Department cannot pay for the expenses related to this referral. Arrangements for payment are entirely between the athlete and the provider.
- [ ] Bill Louisiana Tech Industrial Account

Name____________________ **Soc. Sec. No.**____________________ **Date of Birth**_______________

Sport____________________ **Athletic Trainer Making Referral**____________________

Condition Occurred During [ ] Practice [ ] Competition [ ] Other

Athletic Trainer Comments

*******PLEASE COMPLETE THE INFORMATION BELOW SO THAT WE MAY FOLLOW-UP IN THE CARE OF THIS ATHLETE*******

Physician's Diagnosis

____

____

____

Physician's Recommendations

_____ 1. Activity may be resumed without restriction.

_____ 2. Activity may be continued with appropriate therapy and/or restrictive taping/bracing ____________________

____

_____ 3. No activity other than treatment until (date) ____________________

Recommendations or prescriptions for medication (if any)

____

____

____

Follow-up Plans _____ will see in office in _____ day / week / month____________________

Physician's Signature______________________________ **M.D./D.O. Date**_______________

Pharmacist Signature______________________________ **Date**_______________

Program Data

Paid Claims as of June 30, 2024

Year	Aggregate Deductible	Stop Loss Premium	Administrative Fees	Paid Accident/Injury Claims	Paid Discretionary General Medical Claims
2015-2016	$240,213			$292,280	$3,746
2016-2017	$275,000	$30,000		$283,566	$21,467
2017-2018	$285,000	$22,600	$24,000	$472,220*****	$55,067
2018-2019	$292,500	$23,400	$24,000	$400,649*****	$56,776
2019-2020	$325,000	$30,000	$45,000	$194,744****	$117,155
2020-2021	$351,000	$30,000	$45,000	$361,019***	$286,142
2021-2022	$351,000	$30,000	$45,000	$443,018**	$264,066
2022-2023	$368,000	$31,500	$45,000	$508,011*	$68,376
2023-2024	$385,000	$27,600	$37,500	$172,126	$41,356

*Last year at renewal $133,151 had been paid out on claims

**Two years ago at renewal $125,421 had been paid out on 2021-22 claims. Last yar $376,015 had been paid

***Three years ago at renewal $87,998 had been paid out on 2020-21 claims

****Four years ago at renewal $91,003 had been paid on 2019-20 claims.

*****Five years ago at renewal $94,802 had been paid out on 2018-19 injury claims.

******Six years ago at renewal $106,885 had been paid out on 2017-18 injury claims.

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Year	Aggregate Deductible	Stop Loss Premium	Administrative Fees	Paid Accident/Injury Claims	Paid Discretionary General Medical Claims	Paid Total Claims
2017-2018	$285,000	$22,600	$24,000	$472,220	$55,067	$527,287
2018-2019	$292,500	$23,400	$24,000	$400,649	$56,776	$457,425
2019-2020	$325,000	$30,000	$45,000	$194,744	$117,155	$311,899
2020-2021	$351,000	$30,000	$45,000	$361,019	$286,142	$647,161
2021-2022	$351,000	$30,000	$45,000	$443,018	$264,066	$707,084
2022-2023	$368,000	$31,500	$45,000	$508,011	$68,376	$576,387
2023-2024	$385,000	$27.,600	$37,500	$172,126	$41,356	$213,482

Paid Claims as of June 30, 2024

Census

Intercollegiate Sport Census

Sport	Men	Women
Baseball	48	0
Basketball	15	15
Bowling	0	12
Cross Country	11	7
Football	120	0
Golf	11	0
Soccer	0	30
Softball	0	23
Tennis	0	10
Track & Field	33	30
Volleyball	0	15
Totals	**238**	**142**

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Attachment 2-2

2023-2024
ISS
GLOBAL CARE
ICS PLUS

International Student Health

Insurance Plan

Designed Exclusively for International Students

The attached Certificate of Coverage provides important details regarding your coverage. Coverage is based on ITA Global Trust Ltd. as Trustee of the International Student Health and Wellness Trust Plan 2023-202965-91 and provided by ISS plan 2023-203112-91

Gallagher | Student Health & Special Risk

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There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces.

The Master Policy is a non-renewable one year term insurance Policy. The Master Policy will not be renewed.

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured 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 as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the maximum benefit.

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

Section 4: Pre-Admission Notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; however, pre-notification is not a guarantee that benefits will be paid.

Section 5: Preferred Provider and Out-of-Network Provider Information

This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of Preferred Providers. The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as Out-of-Network Providers. However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus

Preferred Provider Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities.

The easiest way to locate Preferred Providers is to log in to My Account at www.pghstudent.com. The website will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-888-251-6253 for assistance in finding a Preferred Provider.

The Company arranges for health care providers to take part in the Preferred Provider network. Preferred Providers are independent practitioners. They are not employees of the Company. It is the Insured's responsibility to choose a provider. Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

3. **Hospital Miscellaneous Expenses.**
When confined as an Inpatient or as a precondition for being confined as an Inpatient.

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.
- 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. **Routine Newborn Care.**
If provided in the Schedule of Benefits. While Hospital Confined and routine nursery care provided immediately after birth.

Benefits will be paid for an inpatient stay of at least:
- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.

The benefits and the maximum amounts are specified in the Schedule of Benefits.

5. **Surgery.**
Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**
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.**
Registered Nurse's services which are all of the following:
- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

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

9. **Physician's Visits.**
Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:
- CT-scans.
- NMR's.
- Blood chemistries.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections.**
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy.**
See Schedule of Benefits.

24. **Prescription Drugs.**
See Schedule of Benefits.

Other

25. **Ambulance Services.**
See Schedule of Benefits.

26. **Durable Medical Equipment.**
Durable Medical Equipment must be all of the following:
- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment:
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.

If more than one piece of equipment or device can meet the Insured's functional need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

27. **Consultant Physician Fees.**
Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
When services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

37. **Urgent Care Center.**
Benefits are limited to:
- Facility or clinic fee billed by the Urgent Care Center.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

38. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- Facility or clinic fee billed by the Hospital.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

39. **Transplantation Services.**
Organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

40. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

41. **Intercollegiate Sports Injury.**
Injury sustained while the Insured Person is either of the following:
- Actively engaged in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed intercollegiate sports coach or trainer.
- Actually being transported as a member of a group under the direct supervision of a duly delegated representative of the intercollegiate sports team for the purpose of participating in the play or practice of a schedule intercollegiate sport.

Benefits are payable as specified in the attached Intercollegiate Sports Coverage endorsement.

Section 7: Additional Benefits

BENEFITS FOR DRUG TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS

When Prescription Drug benefits are payable under the Policy, benefits will be provided for drugs for treatment of cancer or life threatening conditions although the drug has not been approved by the Food and Drug Administration for that indication if that drug is recognized for treatment of such indication in one of the standard reference compendia or in the appropriate medical literature. If requested, the prescribing Physician must submit documentation supporting the proposed off-label use or uses to the Company. Coverage shall include Medically Necessary services associated with the administration of such drugs.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

ALLOWED AMOUNT means the maximum amount the Company is obligated to pay for Covered Medical Expenses. Allowed amounts are determined by the Company or determined as required by law, as described below.

Allowed amounts are based on the following:

When Covered Medical Expenses are received from a Preferred Provider, allowed amounts are the Company's contracted fee(s) with that provider.

When Covered Medical Expenses are received from an Out-of-Network Provider, allowed amounts are determined based on either of the following:

1. Negotiated rates agreed to by the Out-of-Network Provider and either the Company or one of Our vendors, affiliates or subcontractors.
2. If rates have not been negotiated, then one of the following amounts:
   - Allowed amounts are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographical market, with the exception of the following.
     - 50% of CMS for the same or similar freestanding laboratory service.
     - 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
     - 70% of CMS for the same or similar physical therapy service from a freestanding provider.
   - When a rate for all other services is not published by CMS for the service, the allowed amount is based on 20% of the provider's billed charge.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means health care services and supplies which are all of the following:
1. Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness or Injury.
2. Medically Necessary.
3. Specified as a covered medical expense in this Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
4. Not in excess of the Allowed Amount.
5. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
6. Not excluded in this Certificate under the Exclusions and Limitations.
7. 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.

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under the Policy.

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the Policy, and 2) the appropriate Dependent premium has been paid. 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 constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. 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.
6. Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means a medical condition (including Mental Illness and substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in any of the following:

1. Placement of the Insured's health in jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body organ or part.
4. In the case of a pregnant woman, serious jeopardy to the health of the woman or unborn child.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions.

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1. Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2. Provided for the diagnosis, or the direct care and treatment of the Sickness or 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.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both:

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

The 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 Inpatient confinement.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.

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.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

TELEHEALTH/TELEMEDICINE means live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

URGENT CARE CENTER means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Section 11: 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 any of the following:

1. Acne.
2. Acupuncture.
3. Addiction, such as:
   - Nicotine addiction, except as specifically provided in the Policy.
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
4. Biofeedback.
5. Cosmetic procedures, except reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy or for newborn or adopted children. The primary result of the procedure is not a changed or improved physical appearance.
6. 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.
7. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Foot care for the following:
   - Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery).

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
10. Health spa or similar facilities. Strengthening programs.
11. Home health care.
12. Hospice care.
13. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
15. Injury or Sickness inside the Insured's home country.
16. Injury or Sickness outside the United States and its possessions, except when traveling for academic study abroad programs, business, pleasure or to or from the Insured's home country.
17. Injury or Sickness when claims payment and/or coverage is prohibited by applicable law.
18. Injury sustained while:
    - Participating in any interscholastic or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.

3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Section 13: General Provisions

GRACE PERIOD: A grace period of 14 days will be provided for the payment of each premium payment due after the first premium. The Insured Person's premium must be received during the grace period to avoid a lapse in coverage, and the Insured Person must meet the eligibility requirements each time a premium payment is made.

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 the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company 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 the Policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

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 the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

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 or Sickness 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 issued by 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.

STUDENT ONLY - Schedule of Benefits

ITA GLOBAL TRUST LTD - GLOBAL CARE INTERGOLLEGIATE SPORTS PLUS
2023-202965-91
Injury and Sickness Benefits

Policy Maximum Benefit	No Overall Maximum Dollar Limit
Deductible Preferred Provider	$100 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	70% except as noted below
Out-of-Pocket Maximum Preferred Provider	$6,850 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$10,000 (Per Insured Person, Per Policy Year)

IMPORTANT: This Schedule of Benefits applies to the Named Insured (student) only. Refer to the Dependent Only – Schedule of Benefits for benefits that apply to covered Dependents.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The **Preferred Provider** for this plan is UnitedHealthcare Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. "Network area" means the 50 mile radius around the local school campus the Named Insured is attending.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network Provider Benefits. The services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Provider Copays.

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at the Preferred Provider Benefit level when treatment is rendered at the Student Health Center.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefits limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefits are subject to the Policy Maximum Benefit, unless otherwise specifically stated. All benefit maximums are combined Preferred Provider and Out-of-Network Provider unless otherwise specifically stated. Please refer to the Medical Expense Benefits section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	Allowed Amount after Deductible	Allowed Amount after Deductible
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient		
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	$250 Copay per visit Allowed Amount not subject to Deductible	$250 Copay per visit Allowed Amount not subject to Deductible
Diagnostic X-ray Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests and Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $15 Copay per prescription Tier 1 30% Coinsurance per prescription Tier 2 45% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	No Benefits

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Durable Medical Equipment	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees	$30 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only. $100 maximum per tooth $500 maximum per Policy Year	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Mental Illness Treatment	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment	Paid as any other Sickness	Paid as any other Sickness
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness

DEPENDENT ONLY - Schedule of Benefits

ITA GLOBAL TRUST LTD - GLOBAL CARE INTERGOLLEGIATE SPORTS PLUS
2023-202965-91
INJURY AND SICKNESS BENEFITS

Policy Maximum Benefit	$250,000 (Per Insured Person, Per Policy Year)
Deductible Preferred Provider	$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$750 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	70% except as noted below

IMPORTANT: This Schedule of Benefits applies to covered Dependents only. Refer to the Student Only – Schedule of Benefits for benefits that apply to the Named Insured.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The **Preferred Provider** for this plan is UnitedHealthcare Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefits limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefits are subject to the Policy Maximum Benefit, unless otherwise specifically stated. All benefit maximums are combined Preferred Provider and Out-of-Network Provider unless otherwise specifically stated. Please refer to the Medical Expense Benefits section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	$500 Copay per Hospital Confinement 80% of Allowed Amount not subject to Deductible	$3,000 maximum per day Allowed Amount after Deductible
Intensive Care	$500 Copay per Hospital Confinement 80% of Allowed Amount not subject to Deductible	$4,000 maximum per day Allowed Amount after Deductible
Hospital Miscellaneous Expenses $1,000 maximum per day Physiotherapy is limited to 30 days maximum per Policy Year.	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care $5,000 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Surgery 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 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Tests and Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $15 Copay per prescription Tier 1 25% Coinsurance per prescription Tier 2 40% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	No Benefits

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Durable Medical Equipment $1,000 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees $50 maximum per visit 30 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only. $100 maximum per tooth $500 maximum for each Injury	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Mental Illness Treatment **Inpatient** – 30 days maximum per Policy Year **Outpatient** - $75 maximum per visit 30 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Substance Use Disorder Treatment **Inpatient** – 30 days maximum per Policy Year **Outpatient** - $75 maximum per visit 30 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Maternity $10,000 maximum per Policy Year Conception must occur after the Insured's effective date under this Policy.	Paid as any other Sickness	Paid as any other Sickness

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POLICY ENDORSEMENT

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.

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

INTERCOLLEGIATE SPORTS COVERAGE

Named Insured Only

Section 1: Classes of Persons to be Insured

All student athletes who are members of the following intercollegiate athletic teams: Football, Baseball, Softball, Basketball, Volleyball, Soccer, Cheerleading, Rugby, Golf, Tennis, Rifle, Hockey, Swimming, Track and Field, Equestrian, Wrestling, Boxing, Lacrosse, Gymnastics, and Skating, Cross Country, Rowing, Fencing, Squash, Skiing, Crew, Rodeo, Bowling.

Section 2. Description of Coverage

Benefits will be paid for Injury sustained by an Insured Person while:

- Actually engaged, as an official representative, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer; or
- Actually being transported as a member of a group under the direct supervision of a duly delegated representative for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

Section 3. Medical Expense Benefits

Maximum Benefit	**$10,000 (For Each Injury)**
Deductible Preferred Provider	**$100 (Per Policy Year)**
Deductible Out-of-Network	**$500 (Per Policy Year)**
Coinsurance Preferred Provider	**80%**
Coinsurance Out-of-Network	**70%**

Benefits are payable under the Policy Schedule of Benefits for Covered Medical Expenses less the above stated Deductible incurred due to an Injury as described in Section 2. The total payable for all Covered Medical Expenses will never exceed the Maximum Benefit of $10,000 for any one Injury.

Section 4. Primary Insurance

The "Excess Provision" does not apply to the coverage provided under this endorsement. Benefits for "Intercollegiate Sports" will be paid in addition to other insurance.

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, the Insured Person may notify the Company of such treatment before treatment begins and receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Insured Person know in advance approximately what portion of the expenses will be considered for payment.

Does Pre-Authorization Apply?

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are provided. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.
B. Provided by or under the direction of a Dental Provider.
C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure.
D. Not excluded as described in Section 3: Pediatric Dental Exclusions of this endorsement.

Benefits for Covered Dental Services are subject to satisfaction of the Dental Services Deductible.

Network Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge the Insured Person or the Company for any service or supply that is not Necessary as determined by the Company. If the Insured Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Insured Person. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

Out-of-Network Benefits:

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of the Usual and Customary Fees. The Insured Person must pay the amount by which the out-of-Network provider's billed charge exceeds the Allowed Dental Amounts.

Dental Services Deductible

Benefits for pediatric Dental Services provided under this endorsement are not subject to the Policy Deductible stated in the Policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible.

For any combination of Network and Out-of-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

Out-of-Pocket Maximum - any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy Schedule of Benefits.

Benefits

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single radiographic image D0272 - Bitewings - two radiographic image D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0708 - Intraoral - bitewing radiographic image - image capture only	50%	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	50%	50%
The following service is limited to 2 images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to 2 times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
Fluoride Treatments The following services are limited to 2 times every 12 months. D1206 - Topical application of fluoride varnish	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2161 - Amalgams - four or more surfaces, primary or permanent		
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of 1 time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D3310 - Endodontic therapy anterior tooth (excluding final restoration) D3320 - Endodontic therapy premolar tooth (excluding final restoration) D3330 - Endodontic therapy molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar		
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy (each additional root) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	50%	50%
The following services are not subject to a frequency limit. D2911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%	50%
The following service is limited to a frequency to 1 per lifetime. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit	50%	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)	50%	50%
The following services are not subject to a frequency limit. D5764 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D7140 - Extraction, erupted tooth or exposed root		
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	50%	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth ot tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6040 - Surgical placement of eposteal implant D6050 - Surgical placmement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal)D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 - Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. All orthodontic treatment must be prior authorized. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment	50%	50%

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from an out-of-Network Dental Provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

Reimbursement for Dental Services

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage, The Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:

UnitedHealthcare Dental
ATTN: Claims Unit
P. O. Box 30567
Salt Lake City, UT 84130-0567

If the Insured Person would like to use a claim form, call Customer Service at the number listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in the Definitions section of the Certificate of Coverage:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Allowed Dental Amounts are the Company's contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from out-of-Network Dental Providers, Allowed Dental Amounts are the Usual and Customary Fees, as defined below.

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under this endorsement.

Dental Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary Fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

What Are the Benefit Descriptions?

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination

A routine vision examination of the eyes and according to the standards of care in the area where the Insured Person resides, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) – helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation – how well the Insured Person sees up close (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

The Insured Person is eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Insured Person chooses more than one of these Vision Care Services, the Company will pay benefits for only one Vision Care Service.

If the Insured Person purchases Eyeglass Lenses and Eyeglass Frames at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this endorsement under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided under this endorsement for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Pediatric Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided under this endorsement, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services provided by an out-of-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a UnitedHealthcare Vision Network Vision Care Provider or an out-of-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

H&W INDEMNITY (SPC), LTD. FOR AND ON BEHALF OF STUDENT RESOURCES SP

POLICY ENDORSEMENT

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.

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products when dispensed at a UHCP Network Pharmacy as specified in the Policy Schedule of Benefits subject to all terms of the Policy and the provisions, definitions and exclusions specified in this endorsement.

Benefits for Prescription Drug Products are subject to supply limits and Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the Policy Schedule of Benefits for applicable supply limits and Copayments and/or Coinsurance requirements.

Benefit for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Medical Expense.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

The Insured must either show their ID card to the Network Pharmacy when the prescription is filled or provide the Network Pharmacy with identifying information that can be verified by the Company during regular business hours. If the Insured does not show their ID card to the Network Pharmacy or provide verifiable information, they will need to pay for the Prescription Drug at the pharmacy.

The Insured may then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.pghstudent.com and logging in to their online account or by calling Customer Service at 1-855-828-7716.

Information on Network Pharmacies is available at www.pghstudent.com (or refer to your Summary Brochure for specific website for additional information) or by calling *Customer Service* at 1-855-828-7716.

If the Insured does not use a Network Pharmacy, no benefits are available and the Insured will be responsible for paying the full cost for the Prescription Drug.

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lowest of:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Prescription Drug Charge for that Prescription Drug Product.

As written by the Physician, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to obtain prior authorization from the Company or the Company's designee. The reason for obtaining prior authorization from the Company is to determine whether the Prescription Drug Product, in accordance with the Company's approved guidelines, is each of the following:

- It meets the definition of a Covered Medical Expense.
- It is not an Experimental or Investigational or Unproven Service.

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Company's review and change. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires prior authorization at www.pghstudent.com (or refer to your Summary Brochure for specific website for additional information) or by calling *Customer Service* at 1-855-828-7716.

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

When the Insured submits a claim on this basis, the Insured may pay more because they did not obtain prior authorization from the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

Does Step Therapy Apply?

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. In order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first.

The Insured may find out whether a Prescription Drug Product is subject to step therapy requirements at www.pghstudent.com (or refer to your Summary Brochure for specific website for additional information) or by calling *Customer Service* at 1-855-828-7716.

When Does the Company Limit Selection of Pharmacies?

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's choice of Network Pharmacies may be limited. If this happens, the Company may require the Insured to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the chosen Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will choose a Network Pharmacy for the Insured.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are specifically provided for in the Policy.
- If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the Policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician will be classified as a Generic by the Company.

Maintenance Medication means a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. The Insured may find out if a Prescription Drug Product is a Maintenance Medication at www.pghstudent.com or by calling Customer Service at 1-855-828-7716.

Network Pharmacy means a pharmacy that has:
- Entered into an agreement with the Company or an organization contracting on the Company's behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:
- The date it is placed on a tier by the Company's PDL Management Committee.
- December 31st of the following calendar year.

Preferred 90 Day Retail Network Pharmacy means a retail pharmacy that the Company identifies as a preferred pharmacy within the network for Maintenance Medication.

Prescription Drug Charge means the rate the Company has agreed to pay the Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes a dispensing fee and any applicable sales tax.

Prescription Drug List means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change from time to time. The Insured may find out which tier a particular Prescription Drug Product has been placed at www.pghstudent.com (or refer to your Summary Brochure for specific website for additional information) or call *Customer Service* at 1-855-828-7716.

Prescription Drug List (PDL) Management Committee means the committee that the Company designates for placing Prescription Drugs into specific tiers.

Prescription Drug Product means a medication or product that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the Policy, this definition includes:
- Inhalers.
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;

Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
8. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
9. Certain unit dose packaging or repackagers of Prescription Drug Products.
10. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
11. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
12. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)
13. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
14. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.
15. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
16. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
17. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. A Prescription Drug Product with either:
   - An approved biosimilar.
   - A.biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

   For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

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POLICY ENDORSEMENT

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.

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

An Insured Person under this insurance plan is eligible for Assistance and Evacuation Benefits in addition to the underlying plan coverage. The requirements to receive these benefits are as follows:

International Students, insured spouse, and insured minor child(ren) are eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

Assistance and Evacuation Benefits

DEFINITIONS

The following definitions apply to the Assistance and Evacuation Benefits described further below.

"Emergency Medical Event" means an event wherein an Insured Person's medical condition and situation are such that, in the opinion of the Company's affiliate or authorized vendor and the Insured Person's treating physician, the Insured Person requires urgent medical attention without which there would be a significant risk of death, or serious impairment and adequate medical treatment is not available at the Insured Person's initial medical facility.

"Home Country" means, with respect to an Insured Person, the country or territory as shown on the Insured Person's passport or the country or territory of which the Insured Person is a permanent resident.

"Host Country" means, with respect to an Insured Person, the country or territory the Insured Person is visiting or in which the Insured Person is living, which is not the Insured Person's Home Country.

"Physician Advisors" mean physicians retained by the Company's affiliate or authorized vendor for provision of consultative and advisory services to the Company's affiliate or authorized vendor, including the review and analysis of the medical care received by Insured Persons.

An Insured Person must notify the Company's affiliate or authorized vendor to obtain benefits for Medical Evacuation and Repatriation. If the Insured Person doesn't notify the Company's affiliate or authorized vendor, the Insured Person will be responsible for paying all charges and no benefits will be paid.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

Emergency Medical Evacuation: If an Insured Person suffers a Sickness or Injury, experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the *Medical Director* of the Company's affiliate or authorized vendor, the Company's affiliate or authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

Dispatch of Doctors/Specialists: If an Insured Person experiences an Emergency Medical Event and the Company's affiliate or authorized vendor determines that an Insured Person cannot be adequately assessed by telephone for possible medical evacuation from the initial medical facility or that the Insured Person cannot be moved and local treatment is unavailable, the Company's affiliate or authorized vendor will arrange to send an appropriate medical practitioner to the Insured Person's location when it deems it appropriate for medical management of a case. The Company will pay costs for

2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

Additional Assistance Services

The following assistance services will be available to an Insured Person in addition to the Assistance and Evacuation Benefits.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon an Insured Person's request, the Company's affiliate or authorized vendor will provide referrals to physicians, hospitals, dentists, and dental clinics in the area the Insured Person is traveling in order to assist the Insured Person in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, the Company's affiliate or authorized vendor will continually monitor the Insured Person's medical condition. Third-party medical providers may offer consultative and advisory services to the Company's affiliate or authorized vendor in relation to the Insured Person's medical condition, including review and analysis of the quality of medical care received by the Insured Person.

Facilitation of Hospital Admittance Payments: The Company's affiliate or authorized vendor will issue a financial guarantee (or wire funds) on behalf of Company up to five thousand dollars (US$5,000) to facilitate admittance to a foreign (non-US) medical facility.

Relay of Insurance and Medical Information: Upon an Insured Person's request and authorization, the Company's affiliate or authorized vendor will relay the Insured Person's insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. The Company's affiliate or authorized vendor will also assist with hospital admission and discharge planning.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

Hotel Arrangements: The Company's affiliate or authorized vendor will assist Insured Persons with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: The Company's affiliate or authorized vendor will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

Attachment 2-3

Academic Year Country	23-24 Total Headcount	22-23 Total Headcount	21-22 Total Headcount	20-21 Total Headcount	19-20 Total Headcount	18-19 Total Headcount	17-18 Total Headcount	16-17 Total Headcount
Afghanistan							1	5
Algeria		1						
Angola	2	1	2	3	3	2	2	1
Argentina	2	1	1	2	2	1	1	
Australia	2	3	4	1		2	2	2
Bahamas		1	1	1				
Bangladesh	43	38	20	24	25	20	18	16
Barbados	1	1				1		1
Belgium				1	1	2	2	
Bolivia	2	5	5	5	7	6	8	8
Brazil	4	3	7	4	4	3	1	1
Bulgaria				1	1			
Burma	3	2						
Cameroon			1	2	3	4	6	8
Canada	8	8	5	4	3	6	6	6
Chad				1	1	1		
Chile	1	1			1	1	1	
China	9	10	17	27	41	54	67	76
Colombia	2	2	4	4	4	4	5	1
Côte d'Ivoire	7	7	14	15	17	13	4	1
Croatia		1	1	1	1			
Democratic Republic of th	1	2	1					
Denmark	1							
Dominica	1	2	2	1	1	2	4	2
Egypt	5	3	1	2	1	1	1	1
El Salvador	2	3	1	2	2	2	2	3
Ethiopia							2	2
Finland	1		1					1
France	8	3	1	2	1	1	2	2
French Southern and Anta	2							
Gabon	2	2						1
Georgia	2	3	3					
Germany	7	9	7	2	1	3	2	2
Ghana	1	2	1	1	1			2
Grenada	1							
Guam			1					
Guatemala	1							
Haiti	1	1		1	1		1	1
Honduras	1	1	2	2	2	4	4	1
Hungary		1					1	1
India	58	41	40	44	49	40	39	36
Indonesia	2	2	1	2	1		1	1
Iran	11	9	5	5	10	12	12	13
Ireland	1	1	2	1				
Israel	2	1	1	1	1	1		
Italy	2	3	2		1	1	2	2
Jamaica	6	6	1	1	1	1		1
Japan	1	3	3	3	3			1
Jordan	3	5	4	5	6	7	3	2
Kazakhstan					1	2	3	2
Kenya	1	1			1	2	3	5
Kuwait						1		
Latvia		1					1	1
Lebanon				1	1	1		
Libya			1	1	1	3	2	2
Madagascar	1		1	2	4	4	2	
Malaysia	1	1	1			1	1	1
Mexico	14	13	10	11	12	13	15	11
Morocco	1					2	1	2
Nepal	100	35	25	29	38	46	55	51
Netherlands	2	3	3	2	2	1		2
New Zealand			1			1		
Nigeria	32	26	23	17	22	27	25	20
Niue				1	1	1	1	
Norway	1	1	1	1	1			
Pakistan	11	4	2	1	1	1	1	1
Paraguay								1
Peru				1	1	1		
Philippines	1				1	2	2	2
Poland						1		
Portugal	1	1	1	2				
Qatar						1	1	
Russia	1	1						1
Rwanda	1	1	1	1	1	1	2	2
Saint Lucia							1	3
Saint Vincent and the Gre	1	1						
Saudi Arabia	6	8	14	19	26	36	28	29
Senegal						2	1	1
Serbia	1	2	1	1	1	1		
Sierra Leone				1	1	1		
Singapore		1	1					
Slovakia			1	1	1	1	2	1
South Africa					2	3	2	2
South Korea	4	3	2	2	2	1	3	7
Spain	6	8	8	3	3	5	2	4
Sri Lanka	2	2	5	8	9	8	8	10
Sudan	1	1						1
Svalbard	1	1						
Sweden	1	1	1	2	1			2
Switzerland							1	
Taiwan				1	2	4	4	4
Tajikistan	2	1	1	1	1	1	2	1
Tanzania			1					
Thailand		2	2	2	3	2		1
Trinidad and Tobago						3	3	1
Türkiye	2	1	1					
Turkmenistan	1	1						
Uganda						1	2	1
Ukraine				1		1	1	
United Arab Emirates								2
United Kingdom	2	1	2	3	3	3	1	2
United States	10,054	9,504	9,757	9,768	9,752	10,269	10,711	10,779
Venezuela	3		1	3	2	1	2	4
Vietnam	4	2	5	8	7	10	9	9
Yemen								1
Zambia	1							
Total	10,469	9,816	10,035	10,065	10,100	10,660	11,098	11,170