



Return this **SIGNED** form to:
 Louisiana Tech University
 Office of Purchasing
 PO Box 3157
 208 Keeny Circle, RM 408
 Ruston, Louisiana 71272

INVITATION TO BID

DO NOT SHIP BASED UPON THIS BID

| | |
|---------------------------------|---|
| Bid Number: 50012-656-27 | Bid Title: Participant Accident Coverage for Intercollegiate Athletics |
|---------------------------------|---|

Bid Schedule:

| | |
|---|--|
| Pre-Bid Conference: N/A | Bidder agrees to comply with all conditions below and attached to this request. |
| Bid Submission Deadline / Opening: July 23, 2026 @ 2:00 PM | |

Prices are to be complete and the FOB point is to be Louisiana Tech University unless otherwise specified.

Bidder Information: (Bidder to provide all required information)

| | | | |
|--------------------------------------|---------|---|--|
| (Full Company Name) | | | |
| (Full Street or Mailing Address) | | | |
| (City) | (State) | (Zip) | |
| (Phone) | (Email) | (Fax) | |
| (Company Quote Number if Applicable) | | PRICES MUST BE FIRM FOR AT LEAST 30 DAYS FROM BID OPENING DATE | |

FAILURE TO SIGN BELOW IN INK SHALL DISQUALIFY BID

 Typed or Printed Name / Title

 Authorized Signature

The Louisiana Tech University Office of Purchasing is seeking SEALED BIDS for the following:

Participant Accident Coverage for Intercollegiate Athletics

* This solicitation will result in the issuance of a purchase order covering the timeframe August 1, 2026 to June 30, 2027 with the option to renew for two (2) additional one (1) year period if both parties mutually agree *

** Vendors are REQUIRED to submit a bid bond for this solicitation in the amount of five (5) percent of \$500,000.00 (\$25,000.00). This Bid Bond shall be included in the same envelope as the vendor's bid response. Failure to include the required bid bond will cause the vendor's bid to be deemed as non-responsive **

See Attached Bid Specifications for additional details

ALL BIDS MUST BE RETURNED TO THE LOUISIANA TECH UNIVERSITY OFFICE OF PURCHASING VIA MAIL OR IN PERSON.

The Bidder is solely responsible for ensuring that its courier service provider makes inside deliveries to our physical location. Louisiana Tech University is not responsible for any delays caused by the bidder's chosen means of delivery.

For questions regarding specifications, please contact the Office of Purchasing at 318-257-4205 or purchasing@latech.edu. Please ensure that the above bid number appears on all communications.

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 are not intended to be restrictive. Bids will be considered for any brand which meets or exceeds the quality of the specifications listed for any items.

The Louisiana Tech University Office of Purchasing is now accepting Sealed Bid solicitations for Participant Accident Coverage for Intercollegiate Athletics.

Solicitation Timeline:

June 17, 2026 – Initial posting of the solicitation

July 1, 2026 @ 5:00 PM – Deadline for submission of questions to the University

July 9, 2026 @ 5:00 PM – Deadline for answers to submitted questions to be posted as an addendum

July 23, 2026 @ 2:00 PM – Deadline to receive sealed bids and bid opening

The University is seeking bids from qualified firms for the purpose of establishing a multi-component agreement for insurance coverage for its student-athletes. This solicitation will be awarded to a single vendor based upon the aggregate overall lowest, responsive vendor's pricing of both components.

- Component #1: Secondary Insurance for all student-athletes on an aggregate deductible platform.
- Component #2: International Student-Athlete Health Insurance

This solicitation will result in the issuance of a purchase order covering the time frame August 1, 2026 to June 30, 2026, with the option to renew the agreement for two (2) additional one (1) year periods if both parties mutually agree.

Louisiana Tech University is a state-sponsored university offering degrees at the Associates, Bachelors, and Graduate levels. The student population comes from across the United States and approximately 68 foreign countries. The total enrollment for the University is approximately 12,000 students, which includes approximately 500 International Students. Of these International Students, 40 were student-athletes.

The University maintains relationships with local and area medical providers. Those providers currently include but are not limited to:

- Northern Louisiana Medical Center
- Allegiance Medical (formerly Green Clinic)
- Orthopaedic and Spine Clinic of Louisiana
- Willis-Knighten
- Oral Surgery Associates
- Farrar Endodontics
- Haik Humble Eye Center
- Legacy Outpatient Therapy Services
- Ruston Apothecare

Individual Components:

Component #1: Secondary Insurance

The purpose of this component is to establish an agreement 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 desires to pay for. The non-athletic related expenses would not be applied to the aggregate deductible. The process would generally follow this sequence, a provider billing a student-athlete's 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 awarded vendor. 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 A – Louisiana Tech University Academic Calendar 2026-2027

Attachment B – Brochure from current Intercollegiate Athletics Component #1 plan

Attachment C – Louisiana Tech University Athlete Medical Referral Form

Attachment D – Claims History by Year Reports

Attachment E – Intercollegiate Athletics Sports Census

Component #2: International Student-Athlete Health Insurance

Louisiana Tech University has recently rebid and awarded to Academic HealthPlans Inc. The agreement with Academic HealthPlans Inc. is to provide health insurance coverage for the University's international students, however, the current agreement does not provide coverage for student-athletes involved in Intercollegiate Athletics. The University's Intercollegiate Athletics Department does provide insurance coverage for athletic related injuries to its international student-athletes. Information related to the current coverage is available in attachments to this solicitation.

Attachment A – Louisiana Tech University Academic Calendar 2026-2027

Attachment F - Brochure from current Intercollegiate Athletics Component #2 plan

Attachment G – Enrolled students by country 2025-2026

Eligibility and Coverage Period:

Component #1:

This agreement period shall cover the time frame August 1, 2026 to June 30, 2027. The benefit period shall be one hundred and four (104) weeks from the date of injury provided on the accident claim form. The benefit period shall survive the agreement if the agreement expires or is terminated prior to the conclusion of the benefit period.

Coverage shall remain in effect for the applicable week or month even though a student-athlete may leave the University, the University 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 academic periods (quarters). However, coverage shall be extended into the Summer term / months when the student is engaged in NCAA defined athletic activity. The policy shall have no gaps in coverage regardless of the University's 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.

- The student is a non-immigrant foreign national with a valid passport from their home country.
- The student has been issued a I-20 Certificate of Eligibility by Louisiana Tech University
- The student has been granted F-1 student status by the United States Citizenship and Immigration Services (USCIS)
- The student is a registered for classes at Louisiana Tech University
- The student is an exchange visitor (and their dependents) who have been issued a DS 2023 by the University

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

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

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

The agreement period shall mirror as stated in previous sections of this solicitation. A person who is eligible for coverage shall become an Insured Certificate Holder on the effective dates specified by the policy holder. Coverage shall be in effect

twelve (12) months out of the year. Coverage shall remain in effect for an applicable academic term even though a student may leave school, unless the insured student enter military service, in which coverage would terminate upon entrance.

Students who institutionally withdraw (formerly resignation) after the premium is paid will be fully covered for the remainder of the academic term (quarter). Should a student institutionally withdraw (formerly resignation) from the University while a claim is pending, the coverage shall continue until payment of the maximum amount applicable or until the student is fully recovered, whichever comes first.

ID Cards and Claims Handling Procedure:

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

Prior to the beginning of the effective date of coverage, the Awarded Vendor / Insurance Company shall provide claim forms that will be completed by the University's Sports Medicine staff. The Insurance Company must agree to make a good faith effort to process completed claim forms quickly and efficiently. The claim form shall be simple and easy to complete. The Insurance Company must accept bills and statement forms generated by hospitals, clinics, and attending physicians as supporting documentation. The Awarded Vendor shall provide a toll-free number and have claims representatives available twenty-four (24) hours per day, seven (7) days per week.

Administrative Procedures:

The Awarded Vendor shall be a licensed agent / broker in the State of Louisiana for the Insurance Company represented and must provide evidence of an A or better rating in the A.M. Best rating. The Vendor shall also submit a list of references / other division one universities to whom the vendor has provided medical insurance services. This shall also include a length of service provided.

The Vendor shall also provide a narrative as to their experiences with medical provider discounts in cities where the Sunbelt Conference teams reside. These locations currently include Boone, NC, Conway, SC, Statesboro, GA, Atlanta, GA, Harrisonburg, VA, Huntington, WV, Norfolk, VA, Jonesboro, AR, Lafayette, LA, Mobile, AL, Hattiesburg, MS, Troy, AL, and Monroe, LA.

The Vendor / Insurance Company must be able to demonstrate its experience in finding cost savings and negotiating lower rates for medical services such as diagnostic imaging, surgery / hospital expenses, and physician fees, etc. The Awarded Vendor / Insurance Company will provide samples of these negotiated contracts. Louisiana Tech University does have professional services contracts for medical / dental / vision services with providers that will continue to be honored. A current listing of those providers is listed earlier in this solicitation.

The Vendor / Insurance Company must provide any special agreements that are in place with specialist surgeons across the country. The Awarded Vendor / Insurance Company shall provide details regarding the availability of these special agreements to the University and its student-athletes.

The Vendor / Insurance Company must provide a description of how their policy would handle durable medical equipment (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 but are not limited to: 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 Vendor / Insurance Company (for Component #1 only) shall provide a quote for the administrative fee to handle sickness and non-athletic related claims and expenses that the University, at its discretion, wishes to pay. The Vendor / Insurance Company shall also provide a description of these services and the communications between the University and the Vendor / Insurance Company and the medical provider.

The Vendor / Insurance Company must submit evidence of net worth to be able to meet the requirements of the plan outlined. The Vendor / Insurance Company shall post a surety (bid) bond in an amount sufficient to guarantee payment of all reasonable anticipated claims. Failure to provide this surety (bid) bond will result in the vendor's bid being deemed as non-responsive.

The Awarded Vendor / Insurance Company shall provide, at least monthly, a claims report upon request. The report shall include the amount being claimed by each student-athlete, grand total of amount claimed, and grand total of payments made; all itemized by medical provider. The report shall show total premiums received, and the total benefits paid, by month and cumulatively for the year. Sample copies of a 'Monthly Claims Report' must accompany the bid.

The Vendor / Insurance Company shall state the average time a claim is paid to a provider and the claim given a clean claim submittal.

The Vendor / Insurance Company must possess a client portal which includes secure communication and file submission. Screenshots or temporary access must be provided so that the following can be evaluated:

- HIPPA compliant system that provides real time claims status
- Provide electronic Explanation of Benefits / real time reporting including Date of Service, payment type, check number (if applicable), check date (if applicable), amount paid, and additional billing details deemed necessary
- Ability to communicate via an encrypted email 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 Vendor / Insurance Company will provide any details of all past or pending litigation or claims filed against the company that would negatively impact the Vendor's / Insurance Company's performance or the University's reputation.

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

Payment of Premium:

Component #1:

At the beginning of each fiscal year, the Awarded Vendor / Insurance Company will provide the University with an invoice for the administrative fees and policy premiums, additionally a separate invoice for a set dollar amount for the 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 payment to the Awarded Vendor / Insurance Company for these balances.

Component #2:

At the beginning of each fiscal year, the University will provide the Awarded Vendor / Insurance Company with a list that includes the following; additions and subtractions will be permitted between quarterly billing cycles.

- Name of student-athlete
- Campus identification number

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

Benefit Plans:

Component #1

The medical plans must contain the following minimum provisions:

| | |
|--|--|
| Accident Medical Expense Benefit | \$90,000.00 (NCAA Requirement) |
| Aggregate Deductible Amount | To be determined based upon loss history |
| Deductible Amount | \$0.00 |
| Usual, Customary, & Reasonable | Yes |
| Benefit Period | 104 weeks (from the date of injury) |
| Full Excess Benefits | Yes |
| Accident Death and Dismemberment Indemnity | \$10,000.00 |
| Accident Death and Dismemberment Aggregate | \$500,000.00 |
| Dental Treatment Due to Covered Injury | No limit to max |
| Physiotherapy Benefit | No limit to max |
| Durable Medical Equipment 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 and Recruits Benefit | Yes |
| (including Men's and Women's Basketball PSA's) | |

Component #2:

The medical plans must contain the following minimum provisions:

- No overall maximum dollar limit
- Deductible:
There should be a deductible of not more than \$1,000.00 per each accident or illness for an Insured Certificate Holder, depending on network benefits.
- Medical Benefits:
Subject to exclusions, limitations, and all other provisions of the policy, benefits are to cover at minimum of \$100,000.00 per accident or illness.
- Medical Evacuation Benefits:
The policy will cover up to a maximum benefit of no more than \$50,000.00 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 \$25,000.00 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 country provided the individual's death occurred outside of his or her home country.

- **Intercollegiate Athletics:**
The policy will cover up to a minimum benefit of \$10,000.00 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 infant of an Insured Certificate Holder will automatically be an Insured Individual from the moment of his or her birth for 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 nor more than \$8,000.00 per individual policy holder.

Exclusions:

Vendor / Insurance Company shall submit all exclusions defined by your policy.

Terms and Conditions:

Louisiana Tech University reserves the right to withdraw this solicitation 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 or each respective insurance company. Louisiana Tech University reserves the right to authenticate any and all information contained in the bid or each prospective Vendor / Insurance Company. The University intends to award this solicitation to a single vendor based upon the aggregate overall lowest, responsive pricing of both components added together. The total for Component #1 will be the result of the total of the Administrative Fees added to the Aggregated Deductible added to the Stop Loss Premium. The total for Component #2 will be the result of the total of the per term premium for the three age groups requested.

Questions and Inquiries:

The University has established a deadline for prospective vendors to submit written questions / inquiries regarding this solicitation. All questions / inquiries shall be submitted via email to the Office of Purchasing at purchasing@latech.edu PRIOR to July 1, 2026 @ 5:00 PM CST. Prospective vendors shall include the solicitation number in the subject line of all email communications with the Office of Purchasing. Questions / inquiries not received via email or after the stated deadline will not be addressed or answered. The University will provide answers to these questions / inquiries on or before July 10, 2026 @ 5:00 PM CST via addendum.

Blackout Period:

Once this solicitation is posted and publicly available, prospective vendors are not allowed to communicate with Intercollegiate Athletics personnel regarding this solicitation. All questions / inquiries shall be routed through the Office of Purchasing via email to purchasing@latech.edu.

Submission of Bids:

Prospective vendors shall submit their bid physically to the Office of Purchasing prior to July 23, 2026 at 2:00 PM CST. The submission can be delivered by courier service provider or hand delivered by the prospective vendor. The Bidder is solely responsible for ensuring that its courier service provider makes inside deliveries to our physical location. Louisiana Tech University is not responsible for any delays caused by the bidder's chosen means of delivery. Bids received after the date and time indicated above will not be opened and cannot be evaluated.

Agreement Changes:

No additional changes, enhancements, or modifications to any agreement resulting from this solicitation shall be made without the prior approval of Louisiana Tech University and the Awarded Vendor / Insurance Company. Changes to the agreement include any change in compensation, beginning / ending date of the agreement, scope of work, and / or Awarded Vendor / Insurance Company change through Assignment of Contract process. Any such changes, once approved, will result in the issuance of an amendment or change order to the agreement. Agreement changes may only be made after the first year of the agreement.

Any changes to the stop loss premium rates must be based upon loss experience and cannot exceed the change in the Medical Care portion of the Consumer Price Index. Written notice of intention by the Underwriter to extend the agreement for an additional year and to adjust stop loss premium rates for the next policy year shall be given to the University in writing by May 1st of that year.

Agreement Termination:

Louisiana Tech University reserves the right to terminate this agreement at any time for cause based upon the failure of the Awarded Vendor / Insurance Company to comply with its terms and / or conditions of the agreement or failure to fulfill its performance obligations pursuant to the agreement, provided that Louisiana Tech University shall give the Awarded Vendor / Insurance Company written notice specifying the Awarded Vendor's / Insurance Company's failure. If within thirty (30) days after receipt of such notice, the Awarded Vendor / Insurance Company has not corrected such failure or in the case of failure which cannot be corrected in thirty (30) days, begun correction, then the University may, at its option, place the Awarded Vendor / Insurance Company in default and the agreement shall terminate on the date specified in such notice.

Remedies for Default:

Any claim or controversy arising from this contract shall be resolved by the provisions of LA RS 39:1524 through 39:1526.

Indemnification:

The Awarded Vendor / Insurance Company 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 Awarded Vendor / Insurance Company, under this Agreement, including without limitations claims for refund of fees. The University agrees to indemnify and hold the Awarded Vendor / Insurance Company 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:

It is hereby agreed that the University's Auditor, the Louisiana Legislative Auditor and / or the Office of the Governor, Division of Administration Auditors of Louisiana shall have the option of auditing all accounts of the Awarded Vendor / Insurance Company which relate to this contract.

Proposal Submission Requirements:

Vendors are to include one (1) original, signed and two (2) copies of their submission in a sealed envelope, mailer, or box. The Vendor shall place this solicitation's number, name, and the Vendor name prominently on the outside of the envelope, mailer, or box. Proposals shall be delivered physically delivered to the Office of Purchasing at the address below before 2:00 PM CST on July 23, 2026.

Louisiana Tech University
Office of Purchasing
PO Box 3157 (USPS)
208 Keeny Circle, RM 408 (all other delivery services)
Ruston, LA 71272

Response Requirements:

The following items must be included in the prospective vendor's submission to the University.

- Cover Letter – letter summarizing response signed by an authorized representative of the company
- Table of Contents
- Company Background and Other Information – provide a narrative of background information on your company, including a statement clarifying whether the proposer is a sole proprietor, a partnership, a corporation, or other legal entity, evidence of net worth,
- Plan Description – provide a description of the proposed plan
- Premium – provide a statement of the premiums for the proposed plan for the coverage period
- Exclusions – Describe exclusions as defined by your policy
- 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 being provided student-athlete and international student health insurance services
- Organizational Chart – provide an organizational chart showing the staffing and lines of authority for key personnel to be used
- 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 the proper is authorized to do business in the State of Louisiana and has properly registered and licensed to do so.
- Complete Bid Form for Pricing Page
- Completed Insurance Company Declarations Page
- Sample Monthly Claims Report
- Client portal screenshots or temporary access for evaluation of services
- Details of past or pending litigation or claims filed against the Vendor / Insurance Company that would negatively impact the Vendor's / Insurance Company's performance or the University's reputation, if applicable

Vendors shall complete all pages of this Invitation to Bid, including the printed name and signature of the person submitting the quotation and pricing on the Schedule of Items page. Bid received without this information shall be deemed as non-responsive. Vendors are encouraged to include their own quote for an explanation of your proposed system, BUT this vendor quote shall not be a substitute for this completed Invitation to Bid Form.

Bid Response Form for Pricing

page 10

| | |
|---------------------------------|---|
| Bid Number: 50012-656-27 | Bid Title: Participant Accident Coverage for Intercollegiate Athletics |
|---------------------------------|---|

Vendors shall complete all pages of this Invitation to Bid, including the printed name and signature of the person submitting the proposal and pricing on the Bid Response Form for Pricing. Bids received without this information shall be deemed as non-responsive.

Coverage Component

Cost

Component #1 (Administrative Fees must be consistent for all groups without age limits)

Student-Athlete Only

Administrative Fees (per year) _____

Aggregate Deductible (per year) _____

Stop Loss Premium (per year) _____

Indicate maximum number of students above pricing covers _____

Component #2

International Student-Athlete Only

Age 22 and under (per academic term) _____

Age 23 to 26 (per academic term) _____

Age 27 to 30 (per academic term) _____

Vendor Name: _____

Date: _____

*** Each individual component may be awarded separately or may be awarded in total, whichever is in the best interest of the University. The total for Component #1 will be the result of the total of the Administrative Fees added to the Aggregated Deductible added to the Stop Loss Premium. The total for Component #2 will be the result of the total of the per term premium for the three age groups requested ***

Insurance Company Declarations Page

This page shall be submitted with Bid Response

Each Vendor submitting a bid related to this solicitation shall complete this Declarations Page and return along with their bid response. Failure to complete this declarations page completely and return with your response will cause your bid to be deemed as non-responsive.

Insurance Company Name: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Main Telephone: _____ Toll Free Number: _____

OFFICIAL CONTACT. The University requests that the Bidder designate one person to receive all documents and communications regarding the University. Please identify the Vendor's Primary Point of Contact for the University. (Please print clearly)

Contact Name: _____ Contact Telephone Number: _____

Contact Secondary Telephone Number: _____ Contact Email Address: _____

Best's Policyholder's Rating: _____ Best's Financial Size Category Classification: _____

Please list each college or university insured during previous school year (attach additional pages if required).

College / University #1: _____

Primary Contact Name: _____ Contact Telephone Number: _____

Approximate Premium Volume: _____ Has Vendor insured this College / University for three (3) or more years: Yes No

College / University #2: _____

Primary Contact Name: _____ Contact Telephone Number: _____

Approximate Premium Volume: _____ Has Vendor insured this College / University for three (3) or more years: Yes No

College / University #3: _____

Primary Contact Name: _____ Contact Telephone Number: _____

Approximate Premium Volume: _____ Has Vendor insured this College / University for three (3) or more years: Yes No

College / University #4: _____

Primary Contact Name: _____ Contact Telephone Number: _____

Approximate Premium Volume: _____ Has Vendor insured this College / University for three (3) or more years: Yes No

College / University #5: _____

Primary Contact Name: _____ Contact Telephone Number: _____

Approximate Premium Volume: _____ Has Vendor insured this College / University for three (3) or more years: Yes No

Is the insurance company paying claims: Yes No

If Yes, complete the following related to claims service:

Office location where claims will be paid: _____

Person processing / paying claims: _____ Title: _____

Telephone Number: _____ Email Address: _____

Years of experience of this employee administering student claims: _____

Toll Free Number for claims service / questions / other issues: _____

Will the claim's office provide copies of all claim's status to the University: Yes No

Will the claim's office provide information on all claims rejected and the reason(s) for the rejection: Yes No

What is the average time for a claim to be processed after the date received by the insurance company: _____

Provide a summary of the insurance company's procedures in processing claims when notice of claim is submitted beyond the policy's time limit?

What at the insurance company's procedures in processing claims when written proof of loss is submitted more than ninety (90) days after the date of such loss:

Will the insurance company furnish the University with a monthly listing of all claims paid, including but not limited to:

| | | |
|------------------------|------------------------------|-----------------------------|
| Claim | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insured's Name | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of Claim incurred | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of Claim paid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Amount of claim | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Company paid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Will the insurance company provide online access to claims forms and the capability of submitting claims: Yes No

By signing this Declarations Page, the Vendor certifies that all information contained therein is true, correct, and accurate, and that the University can contact the listed University's above to obtain an evaluation of the vendor's performance.

Signature of Bidder's Authorized Representative: _____

(Signature SHALL be **HAND SIGNED** in ink. Typed signatures are not allowed)

Date of Signature: _____

Failure to return this completed and properly signed Declarations Page along with the bid response shall cause the vendor's bid to be deemed as non-responsive.



Louisiana Tech University

Division of Finance
Office of Purchasing

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 Office of Purchasing prior to the bid opening date. All responses and/or addenda will be officially submitted by the Louisiana Tech University Office of Purchasing 72 (seventy-two) 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. Bid prices shall also include all customs clearance, duties, and taxes into the United States; if applicable. This is to include, but is not limited to, customs broker fees, document fees, duties, taxes, etc. The University does not retain, nor will it retain a customs broker. All importation shall be the responsibility and at the cost of the Vendor. 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. The Bidder is solely responsible for ensuring that its courier service provider makes inside deliveries to our physical location. The University is not responsible for any delays caused by the bidder's chosen means of delivery. Bidder is solely responsible for the timely delivery of its bid. Bids received after the due date and time will not be considered.
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 assessed 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 shall 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.

35. Prohibition of Companies That Discriminate Against Firearm and Ammunition Industries - In accordance with La. R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of \$100,000 or more involving a for-profit company with at least fifty full-time employees: Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this contract, the Bidder, Proposer or Contractor certifies the following: 1. The company does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association; 2. The company will not discriminate against a firearm entity or firearm trade association during the term of the contract based solely on the entity's or association's status as a firearm entity or firearm trade association. The State reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

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.louisiana.gov.

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

Attachment A

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following pages include the schedule of classes for the 2026-2027 Academic Year for Louisiana Tech University.

Louisiana Tech University

[ARCHIVED CATALOG]

Fall Quarter 2026

FALL QUARTER 2026 (TERM 271)

approved November 1, 2024

| | | | |
|-----|----|---|---|
| Sep | 7 | M | LABOR DAY: UNIVERSITY CLOSED |
| | 9 | W | FALL QUARTER 2026 BEGINS |
| | 9 | W | General Registration/Fee Payment (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –5:00 pm (Keeny Hall 207 & 103) |
| | 9 | W | Placement Exams |
| | 9 | W | Payment Deadline 5 pm |
| | 10 | R | CLASSES BEGIN |
| | 10 | R | Late Registration and Drop/Add begins |
| | 14 | M | Late Registration ends: Last day for Drop/Add and “no-grade” drops |
| | 22 | T | 9th class day, Census Date |
| | 25 | F | Last day to register for Fall graduation (F, Wk 3) |
| Oct | 2 | F | Deadline for completing “I” grade work from Spring/Summer (F, WK 4) |
| | 9 | F | Deadline for faculty submission of “I” grade work from Spring/Summer (F, Wk 5) |
| | 26 | M | Advising beings for currently enrolled students |
| | 30 | F | Last day to drop courses or resign with “W” grades (“F” grades after this date) (F, Wk 8) |
| Nov | 2 | M | Early Web Registration Begins for Winter Quarter 2026-2027 (for students enrolled in Fall Quarter 2026) |
| Nov | 2 | M | Veterans, and Degree Candidate Seniors ≥ 110 hours – Early Registration @ 9:00 am |
| | 2 | M | Honors Students, Grad Students, & Eligible Athletes – Early Registration @ 2:00 pm |
| | 3 | T | Seniors ≥ 100 hours – Early Registration @ 9:00 am |
| | 3 | T | Seniors ≥ 90 hours – Early Registration @ 2:00 pm |
| | 4 | W | Juniors ≥ 80 hours – Early Registration @ 9:00 am |

| | | |
|----|---|--|
| 4 | W | Juniors ≥ 71 hours – Early Registration @ 2:00 pm |
| 5 | R | Juniors ≥ 60 hours – Early Registration @ 9:00 am |
| 6 | F | Sophomores ≥ 49 hours – Early Registration @ 9:00 am |
| 6 | F | Sophomores ≥ 41 hours – Early Registration @ 2:00 pm |
| 9 | M | Sophomores ≥ 30 hours – Early Registration @ 9:00 am |
| 10 | T | Freshmen ≥ 13 hours – Early Registration @ 9:00 am |
| 10 | T | Freshmen ≥ 9 hours – Early Registration @ 2:00 pm |
| 11 | W | Freshmen ≥ 1 hour – Early Registration @ 9:00 am |
| 17 | T | Degree candidate grades due by 3:30 p.m. |
| 19 | R | LAST DAY OF CLASSES |
| 20 | F | Early Web Registration Ends for Winter Quarter 2026-2027 |
| 21 | S | Fall Commencement Exercises, Thomas Assembly Center @ 10 a.m. |
| 21 | S | FALL QUARTER 2026 ENDS |
| 23 | M | All other grades due by 3:30 p.m. |
| 24 | T | Grades “live” for Students |
| 26 | R | THANKSGIVING HOLIDAY: UNIVERSITY CLOSED |
| 27 | F | THANKSGIVING HOLIDAY: UNIVERSITY CLOSED |

Louisiana Tech University

[ARCHIVED CATALOG]

Winter Quarter 2026-2027

WINTER QUARTER 2027 (TERM 272)

approved November 1, 2024

| | | | |
|-----|---|---|---|
| No | 2 | R | THANKSGIVING HOLIDAY: UNIVERSITY CLOSED |
| v | 6 | | |
| | 2 | F | THANKSGIVING HOLIDAY: UNIVERSITY CLOSED |
| | 7 | | |
| De | 1 | T | WINTER QUARTER 2026-2027 BEGINS |
| c | | | |
| | 1 | T | General Registration/Fee Payment (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –5:00 pm (Keeny Hall 207 & 103) |
| | 1 | T | Placement Exams |
| | 1 | T | Payment Deadline |
| | 2 | W | CLASSES BEGIN |
| | 2 | W | Late Registration and Drop/Add begins |
| | 4 | F | Late Registration ends: Last day for Drop/Add and “no-grade” drops |
| | 1 | M | 9th class day, Census Date |
| | 4 | | |
| | 1 | F | Last day to register for Winter graduation (F, Wk 3) |
| | 8 | | |
| | 2 | M | CHRISTMAS HOLIDAY BEGINS: UNIVERSITY CLOSED |
| | 1 | | |
| Jan | 4 | M | CHRISTMAS HOLIDAYS ENDS. Classes resume @ 8 a.m. |
| | 8 | F | Deadline for completing “I” grade work for Fall (F, Wk 4) |
| | 1 | F | Deadline for faculty submission of “I” grade work from Fall (F, Wk 5) |
| | 5 | | |
| | 1 | M | MLK, Jr. BIRTHDAY OBSERVANCE: UNIVERSITY CLOSED |
| | 8 | | |
| Feb | 1 | M | Advising beings for currently enrolled students |
| | 5 | F | Last day to drop courses or resign with “W” grades (“F” grades after this date) (F, Wk 8) |
| | 8 | M | Mardi Gras Holiday: University Closed |
| | 9 | T | Mardi Gras Holiday: University Closed |

| | | | |
|----|----|---|---|
| | 10 | W | University Offices Reopen - No Classes |
| | 11 | R | Early Web Registration Begins for Spring and Summer Quarter 2027 (for students enrolled in Winter Quarter 2026-2027) |
| | 11 | R | Veterans, and Degree Candidate Seniors \geq 110 hours – Early Registration @ 9:00 am |
| | 11 | R | Honors Students, Grad Students, & Eligible Athletes – Early Registration @ 2:00 pm |
| | 12 | F | Seniors \geq 100 hours – Early Registration @ 9:00 am |
| | 12 | F | Seniors \geq 90 hours – Early Registration @ 2:00 pm |
| | 15 | M | Juniors \geq 80 hours – Early Registration @ 9:00 am |
| | 15 | M | Juniors \geq 71 hours – Early Registration @ 2:00 pm |
| | 16 | T | Juniors \geq 60 hours – Early Registration @ 9:00 am |
| | 17 | W | Sophomores \geq 49 hours – Early Registration @ 9:00 am |
| | 17 | W | Sophomores \geq 41 hours – Early Registration @ 2:00 pm |
| | 18 | R | Sophomores \geq 30 hours – Early Registration @ 9:00 am |
| | 19 | F | Freshmen \geq 13 hours – Early Registration @ 9:00 am |
| | 19 | F | Freshmen \geq 9 hours – Early Registration @ 2:00 pm |
| | 22 | M | Freshmen \geq 1 hour – Early Registration @ 9:00 am |
| Ma | 1 | M | Degree candidate grades due by 3:30 p.m. |
| r | 2 | T | LAST DAY OF CLASSES |
| | 3 | W | Early Web Registration Ends for Spring Quarter 2027 |
| | 4 | R | All other grades due by 3:30 p.m. |
| | 5 | F | Grades “live” for Students |
| | 6 | S | Winter Commencement Exercises, Thomas Assembly Center @ 10 a.m. |
| | 6 | S | WINTER QUARTER 2026-2027 ENDS |

Louisiana Tech University

[ARCHIVED CATALOG]

Spring Quarter 2027

SPRING QUARTER 2027 (TERM 273)

approved November 1, 2024

| | | | |
|----|----|---|---|
| Ma | 9 | T | SPRING QUARTER 2027 BEGINS |
| r | 9 | T | General Registration/Fee Payment (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –5:00 pm (Keeny Hall 207 & 103) |
| | 9 | T | Placement Exams |
| | 9 | T | Payment Deadline |
| | 10 | W | CLASSES BEGIN |
| | 10 | W | Late Registration and Drop/Add begins |
| | 12 | F | Late Registration ends: last day for Drop/Add and “no grades” drops |
| | 22 | M | 9th class day, Census Date |
| | 25 | R | Last day to register for Spring graduation (F, Wk 3) |
| | 26 | F | EASTER HOLIDAY: UNIVERSITY CLOSED |
| | 29 | M | EASTER HOLIDAY ENDS. Classes resume @ 5:00 p.m. |
| Ap | 2 | F | Deadline for completing “I” grade work from Winter (F, Wk 4) |
| r | 9 | F | Deadline for faculty submission of “I” grade work from Winter (F, Wk5) |
| | 26 | M | Advising begins for currently enrolled students |
| | 30 | F | Last day to drop courses or resign with “W” grades (“F” grades after this date) (F, Wk 8) |
| Ma | 3 | M | Early Web Registration Begins for Fall Quarter 2027 (for students enrolled in Spring Quarter 2027) |
| y | 3 | M | Veterans, and Degree Candidate Seniors ≥ 110 hours – Early Registration @ 9:00 am |
| | 3 | M | Honors Students, Grad Students, & Eligible Athletes – Early Registration @ 2:00 pm |

| | | |
|----|---|--|
| 4 | T | Seniors ≥ 100 hours – Early Registration @ 9:00 am |
| 4 | T | Seniors ≥ 90 hours – Early Registration @ 2:00 pm |
| 5 | W | Juniors ≥ 80 hours – Early Registration @ 9:00 am |
| 5 | W | Juniors ≥ 71 hours – Early Registration @ 2:00 pm |
| 6 | R | Juniors ≥ 60 hours – Early Registration @ 9:00 am |
| 7 | F | Sophomores ≥ 49 hours – Early Registration @ 9:00 am |
| 7 | F | Sophomores ≥ 41 hours – Early Registration @ 2:00 pm |
| 10 | M | Sophomores ≥ 30 hours – Early Registration @ 9:00 am |
| 11 | T | Freshmen ≥ 13 hours – Early Registration @ 9:00 am |
| 11 | T | Freshmen ≥ 9 hours – Early Registration @ 2:00 pm |
| 12 | W | Freshmen ≥ 1 hour – Early Registration @ 9:00 am |
| 19 | W | Degree candidate grades due by 3:30 p.m. |
| 21 | F | LAST DAY OF CLASSES |
| 22 | S | Spring Commencement Exercises, Thomas Assembly Center |
| 22 | S | SPRING QUARTER 2027 ENDS |
| 25 | T | All other grades due by 3:30 p.m. |
| 26 | W | Grades “live” for Students |
| 31 | M | MEMORIAL DAY HOLIDAY: UNIVERSITY CLOSED |

[ARCHIVED CATALOG]

Summer Quarter 2027

SUMMER QUARTER 2027 (TERM 274)

approved November 1, 2024

| | | | |
|-----|---|---|---|
| Ma | 3 | M | MEMORIAL DAY HOLIDAY: UNIVERSITY CLOSED |
| y | 1 | | |
| Jun | 2 | W | SUMMER QUARTER 2027 Begins |
| | 2 | W | General Registration/Fee Payment (for all new/readmitted students & those continuing students who did not complete early registration & fee payment): 8:15 am –5:00 pm (Keeny Hall 207 & 103) |
| | 2 | W | Placement Exams |
| | 2 | W | Payment Deadline |
| | 3 | R | CLASSES BEGIN: 12-week and 1st 6-week session (Sections 30-37) |
| | 3 | R | Late Registration and Drop/Add begins: 12 week and 1 st 6-week session |
| | 7 | M | Late Registration ends: last day for Drop/Add and “no grades” drops for 12-week and 1st 6-week session |
| | 1 | M | CLASSES BEGIN: 1st 3-week session (Sections 38-39) |
| | 4 | | |
| | 1 | T | Last day for Drop/Add and “no-grade” drops for 1st 3-week session |
| | 5 | | |
| | 1 | T | 9th class day, Census Date |
| | 5 | | |
| | 1 | F | Last day to register for Summer graduation (F, Wk 3) |
| | 8 | | |
| | 2 | W | Last day to drop courses or resign with “W” grades for the 1 st 3-week session |
| | 3 | | |
| | 2 | M | Last day to drop courses or resign with “W” grades for the 1 st 6-week session |
| | 1 | | |
| Jul | 2 | F | LAST DAY OF CLASSES: First 3-week session (Sections 38-39) |
| | 5 | M | INDEPENDENCE DAY: UNIVERSITY CLOSED |
| | 8 | R | LAST DAY OF CLASSES: First 6-week session (Sections 30-37) |
| | 1 | M | CLASSES BEGIN: Second 6-week session (Sections 60-67) |
| | 2 | | |
| | 1 | M | CLASSES BEGIN: Second 3-week session (Sections 68-69) |
| | 2 | | |

| | | |
|--------------|---|--|
| 1 2 | M | Late Registration and Drop/Add begins: second 3- and 6-week sessions only |
| 1 3 | T | Late Registration ends: Last day for Drop/Add and “no-grade” drops for 2nd 3- and 6-week sessions only |
| 1 4 | W | Grades for 1st 6-week and 3-week session classes due by 3:30 p.m. (W, Wk 7) |
| 2 1 | W | Last day to drop courses or resign with “W” grades for the 2 nd 3-week session |
| 2 3 | F | Last day to drop courses or resign with “W” grades for the 12-week session (F, Wk 8) |
| 2 8 | W | Last day to drop courses or resign with “W” grades for the 2 nd 6-week session |
| 3 0 | F | LAST DAY OF CLASSES: Second 3-week session (sections 38-39) |
| Au g 0 | T | Degree candidate grades due by 3:30 p.m. |
| 1 3 | F | LAST DAY OF CLASSES: 12-week and second 6-week session |
| 1 4 | S | Summer Commencement Exercises, Thomas Assembly Center @ 10 a.m. |
| 1 4 | S | SUMMER QUARTER 2026 ENDS |
| 1 7 | T | All grades (including Degree Candidate grades) due by 3:30 p.m. |
| 1 8 | W | Grades “live” for Students |

Attachment B

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following pages include information related to the current Component #1 policy utilized by Intercollegiate Athletics.

MUTUAL OF OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza
Omaha, NE 68175



Mutual of Omaha

Home Office Use Only
Policy Number(s):

Participant Accident Insurance Application

SR2014-F-LA-P-051085-475

Applicant (Full Legal Name) Louisiana Tech University

Address PO Box 4157, 408 Keeny Hall

City Ruston State LA Zip 71272

Requested Effective Date 09/01/2025

If this application is approved, insurance will become effective on the requested effective date, unless Mutual of Omaha Insurance Company sends written notice of a different effective date.

ACKNOWLEDGEMENT AND SIGNATURE

All statements in this application and any claims experience data provided to Mutual of Omaha Insurance Company are true and complete and will be relied upon by Mutual of Omaha Insurance Company to determine whether to issue a policy. Such statements and claims experience data, along with the group insurance proposal from Mutual of Omaha Insurance Company, are the basis for any policy issued by Mutual of Omaha Insurance Company. Any incomplete, incorrect or misleading statements or data may void this application and any issued policy as of the effective date.

If an authorized representative at Mutual of Omaha Insurance Company's Home Office does not approve this application, no insurance is in effect at any time and any premium payment received will be returned.

This application is submitted with a premium payment of \$ \$36,999

Signature of Applicant's Authorized Representative

Typed or Printed Name of Authorized Representative Dan Buckley

Title _____ **Date** 6/30/2025

Name of broker, agent and/or insurance agency Gallagher Special Risk

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of a crime and may subject such person to criminal and civil penalties.

Arkansas, District of Columbia, Louisiana, New Mexico, West Virginia Fraud Warning: 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.

California Fraud Warning: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SCHEDULE

POLICY NO.: SR2014-F-LA-P-051085-475

POLICYHOLDER INFORMATION:

Louisiana Tech University
PO Box 4157, 408 Keeny Hall
Ruston, LA 71272

Effective Date: September 1, 2025

Expiration Date: September 1, 2026

ELIGIBILITY:

- Class 1: All intercollegiate student athletes are eligible and will be covered while participating in the Sports listed below.
- Class 2: Student Cheerleaders are eligible and will be covered while participating in the Sports listed below.
- Class 3: Prospective student athletes while on campus during an official visit for which the athlete was invited by the Policyholder/Sponsoring Organization.
- Class 4: Up to two chaperones of prospective athletes insured under Class 3, while the chaperones are on campus during an official visit by the athlete, in any combination of the following:
- 1) legal guardian;
 - 2) spouse;
 - 3) parents;
 - 4) siblings,
 - 5) grandparents; and
 - 6) aunts/uncles
- whose names are reported to, and on file with, the Policyholder/Sponsoring Organization prior to a prospective athlete's official visit.
- Class 5: All intercollegiate student athletes are eligible and will be covered while participating in non-sports related school activities on premises.

SCOPE OF COVERAGE:

| <u>Class</u> | <u>Insured Risk</u> | <u>Benefits</u> |
|--------------|---------------------------------|---|
| 1 & 2 | Activity Coverage (IRACTATH015) | AD&D (ADDPERC001) Heart or Circulatory Malfunction (HRTCIRMAL001) AME (AMEICS001) |
| 3 | Activity Coverage (IRACTATH016) | AD&D (ADDPERC001) Heart or Circulatory Malfunction (HRTCIRMAL001) AME (AMEICS001) |
| 4 | Activity Coverage (IRACT071) | AD&D (ADDPERC001) AME (AMEICS001) |
| 5 | Activity Coverage (IRSCH018) | AME (AMEICS001) |

COVERED SPORTS:

Men’s Intercollegiate Sports: Baseball, Basketball, Cheerleading, Cross Country Running, Fall Football, Golf, Track/Field.

Women’s Intercollegiate Sports: Basketball, Bowling, Cheerleading, Cross Country Running, Soccer, Softball, Tennis, Track/Field, Volleyball.

BENEFITS:

Accidental Death & Specific Loss Air Only Aggregate Limit of Liability (TBAGGLIM001) \$1,000,000.00

Accidental Death & Specific Loss (Classes 1-4 Only) (ADDPERC001)
Principal Sum Amount \$25,000.00
Loss Period Loss within 365 Days of Injury

Heart or Circulatory Malfunction (Classes 1, 2 & 3 Only) (HRTCIRMAL001)
Maximum Benefit Amount – Loss of Life \$25,000.00
Malfunction Loss Period Within 24 hours after Participation
Loss Period – Loss of Life 90 Days from the accident date

Full Excess Medical Expense for Accident (includes Expanded Medical & Re-Injury) (AMEICS001) & (TBE001)
Classes 1, 2 & 3 Medical Expense Maximum \$90,000.00 per Injury
Class 4 Medical Expense Maximum \$10,000.00 per Injury
Class 5 Medical Expense Maximum \$5,000.00 per Injury
Classes 1-4 Accident Medical Deductible - Reducing \$0.00 per Injury
Classes 1-4 Accident Medical Deductible – Aggregate \$500,000.00
Class 5 Accident Medical Deductible \$0.00 per Injury
Loss Period Initial treatment received within 90 days of accident date
Benefit Period Benefits payable for 104 weeks from accident date

The following riders are attached to and made a part of this policy:
Guaranty Association Act Notice M20816_0217

ANNUAL PREMIUM: \$36,999.00

070925:scs



3300 Mutual of Omaha Plaza
Omaha, NE 68175

This policy is issued to Louisiana Tech University ("the Policyholder").

This policy is a legal contract between the Policyholder and Us. It is issued in consideration of payment of premiums.

This policy is issued in and will be interpreted by the laws of the State of Louisiana, without giving effect to the principles of conflicts of law of that State or any other state. Any part of this policy which is in conflict with the laws of the State of Louisiana is changed to conform to the minimum requirements of that State's laws.

We agree to pay benefits subject to the terms, conditions, and limitations of this policy.

EFFECTIVE DATE AND POLICY TERM

This policy takes effect on September 1, 2025 (the Policy Effective Date) at the Policyholder's main office. It expires on September 1, 2026.

POLICY NUMBER: SR2014-F-LA-P-051085-475

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

A handwritten signature in black ink that reads "James T. Blackledge".

Chief Executive Officer

A handwritten signature in black ink that reads "Terrance S. DeWald".

Corporate Secretary

TABLE OF CONTENTS

PAGE

- INSURED RISKS..... 1**
 - Activity Coverage (IRACTATH015) – Classes 1 & 2 1
 - Activity Coverage (IRACTATH016) – Class 3..... 1
 - Activity Coverage (IRACT071) – Class 4..... 1
 - Activity Coverage (IRSCH018) – Class 5 1
- ELIGIBILITY FOR BENEFITS 2**
 - Eligibility 2
 - When Insurance Begins 2
 - Change in Coverage 2
 - When Insurance Ends..... 2
- DESCRIPTION OF BENEFITS..... 3**
 - Accidental Death and Specific Loss Benefit (ADSLPERC001)..... 3
 - Heart or Circulatory Malfunctions Benefit (HRTCIRMAL001)..... 3
 - Medical Expense for Accident Benefit (AMEICS001)..... 3
- EXCLUSIONS (EXICS001-LA) 5**
- TERMS OF BENEFIT PAYMENTS 6**
 - Full Excess Medical Expense (TBFE001)..... 6
 - Air Only Aggregate Limit of Liability (TBAGGLIM001)..... 6
 - Non-Duplication of Benefits 6
- CLAIM PROVISIONS 7**
 - Notice of Claim 7
 - Claim Forms..... 7
 - Proof of Loss 7
 - Payment of Claims..... 7
 - Opportunity to Request an Appeal 8
 - Authority to Interpret Policy..... 8
- PREMIUM PROVISIONS 9**
 - Reporting Requirements 9
 - Grace Period..... 9
 - Changes in Rates..... 9
 - Reinstatement After Termination 9
- GENERAL PROVISIONS..... 10**
 - Insurance Contract 10
 - Workers Compensation Insurance..... 10
 - Policyholder Records 10
 - Reimbursement/Subrogation 10
 - Policy Termination..... 11
 - Conformity with State Statutes..... 11
 - Legal Actions..... 12
 - Certificates of Insurance..... 12
 - Extension of Time Limits 12
- DEFINITIONS..... 13**

INSURED RISKS

Unless otherwise stated in the Schedule, We will pay benefits for a loss only once, even if coverage was provided under more than one insured risk.

ACTIVITY COVERAGE (IRACTATH015) – CLASSES 1 & 2

We will pay the benefits in this policy for an Insured while:

- participating in a Sponsored or Supervised Activity;
- participating in regularly scheduled athletic games or competition or practice sessions for the sports specified in the Schedule;
- participating in Off-season Physical Conditioning for the sport(s) specified in the Schedule;
- traveling as part of a group in transportation authorized or arranged by the Sponsoring Organization.

ACTIVITY COVERAGE (IRACTATH016) – CLASS 3

We will pay the benefits in this policy for an Insured while:

- participating in a Sponsored or Supervised Activity;
- participating in regularly scheduled athletic games or competition or practice sessions for the sports specified in the Schedule;
- traveling as part of a group in transportation authorized or arranged by the Sponsoring Organization.

ACTIVITY COVERAGE (IRACT071) – CLASS 4

We will pay the benefits in this policy for an Insured while:

- participating in a Sponsored or Supervised Activity;
- traveling as part of a group in transportation authorized or arranged by the Sponsoring Organization.

ACTIVITY COVERAGE (IRSCH018) – CLASS 5

We will pay the benefits in this policy for an Insured while:

- attending School or participating in a Sponsored or Supervised Activity while on Sponsoring Organization premises.

ELIGIBILITY FOR BENEFITS

ELIGIBILITY

Persons who are eligible to be an Insured under this policy are described in the Schedule. This includes persons who may become eligible while this policy is in force.

WHEN INSURANCE BEGINS

Insurance for an Insured begins on the later of:

- the Policy Effective Date; or
- the day the Insured becomes eligible under the terms of this policy.

CHANGE IN COVERAGE

Any change in the Insured's coverage because of change of class as shown in the Schedule will become effective on the date of the change.

WHEN INSURANCE ENDS

Insurance for an Insured will end on the earliest of the date:

- the Insured is no longer eligible;
- the Insured enters full time active duty in any Armed Forces;
- any premium for the Insured is due and unpaid, subject to the Grace Period provision; or
- this policy is terminated.

Termination of insurance will not affect a claim incurred while coverage was in effect.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT (ADSLPERC001)

If an Insured suffers a loss listed below from an Accident within the Loss Period stated in the Schedule, We will pay the benefit opposite the Loss. If the Insured sustains more than one loss as the result of one Accident, We will pay only the largest benefit to which the Insured is entitled.

The Principal Sum is shown in the Schedule.

**TABLE OF BENEFITS FOR
ACCIDENTAL DEATH AND SPECIFIC LOSS**

| <i>Loss</i> | <i>Benefit Amount</i> |
|--|-----------------------|
| Loss of Life | 100% of Principal Sum |
| Loss of Both Hands | 100% of Principal Sum |
| Loss of Both Feet | 100% of Principal Sum |
| Loss of Entire Sight of Both Eyes | 100% of Principal Sum |
| Loss of One Hand and One Foot | 100% of Principal Sum |
| Loss of One Hand and Entire Sight of One Eye | 100% of Principal Sum |
| Loss of One Foot and Entire Sight of One Eye | 100% of Principal Sum |
| Loss of Speech and Hearing | 100% of Principal Sum |
| Loss of Entire Sight of One Eye | 50% of Principal Sum |
| Loss of Speech or Hearing | 50% of Principal Sum |
| Loss of One Hand or One Foot | 50% of Principal Sum |
| Loss of Thumb and Index Finger | 25% of Principal Sum |

HEART OR CIRCULATORY MALFUNCTIONS BENEFIT (HRTCIRMAL001)

We will pay Heart or Circulatory Malfunctions Benefits to an Insured if the Insured receives medical treatment for a Heart or Circulatory Malfunction.

Benefits are subject to the Malfunction Loss Period shown in the Schedule.

We will pay the applicable benefits shown in the Schedule.

Loss of Life Benefit

We will pay the Loss of Life benefit shown in the Schedule if the Heart or Circulatory Malfunction results in the Insured's death within the Loss Period of participation in a Sponsored or Supervised Activity which caused the malfunction.

For the Loss of Life benefit, the Heart or Circulatory Malfunction is limited to a myocardial infarction, coronary thrombosis, or cerebral vascular accident.

MEDICAL EXPENSE FOR ACCIDENT BENEFIT (AMEICS001)

We will pay the following Medical Expenses incurred as a result of an Accident. The Medical Expense Maximum and any applicable sub-limit amounts are shown in the Schedule.

1. Hospital room and board charges, up to the average semi-private daily room rate, for each day in the Hospital;
2. Intensive Care Unit charges are payable in lieu of payment for Hospital room and board charges for each day the Insured is confined in an intensive care unit;
3. Hospital miscellaneous charges during a hospital confinement. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items;
4. outpatient charges by a Hospital for:
 - a. emergency room treatment. Treatment must be received within 72 hours of the Accident;
 - b. emergency room physician; or

- c. use of surgical facilities;
- 5. surgical charges for the primary performance of a surgical procedure by a Physician subject to the following:
 - a. if bilateral or multiple surgical procedures are performed by one Physician, We will pay the Medical Expenses for the primary procedure;
 - b. for each procedure that is not the primary procedure performed through the same incision as the primary procedure, we will pay 50% of the amount otherwise payable if the additional procedure were the primary procedure;
 - c. if multiple surgical procedures are performed during the same operating session, reimbursement shall be based upon, 100% of Allowable Expense for the primary procedure, 50% of Allowable Expense for the secondary procedure and 25% of Allowable Expense for the third and subsequent procedures;
 - d. any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental and no benefits will be provided for such procedure;
 - e. if multiple unrelated surgical procedures are performed by two or more Physicians on separate operative fields, benefits will be based on the Medical Expenses for each Physician's primary procedure; and
 - f. if two or more Physicians perform a procedure that is normally performed by one Physician, We will only pay the Medical Expenses for the primary Physician;
- 6. charges for a second surgical opinion or consultation by a Physician;
- 7. surgical charges for assistant surgeon duties will be reimbursed at 25% of the allowable for surgery codes that have been assigned an assistant surgery indicator by the Centers for Medicare & Medicaid Services;
- 8. charges for anesthesia and its administration for surgery;
- 9. Physician's charges for other than pre- or post-operative care for in-Hospital visits or office visits;
- 10. charges for, including Physician's charges for reading or interpreting the results of, Laboratory Tests and diagnostic imaging including X-Ray, MRI, or CAT Scan;
- 11. charges for nursing services, other than routine Hospital care, by or under the supervision of a Nurse;
- 12. treatment of the spine by manual or mechanical means;
- 13. charges for Durable Medical Equipment;
- 14. charges for physiotherapy which includes:
 - a. adjustment;
 - b. diathermy;
 - c. heat treatment;
 - d. manipulation;
 - e. microtherm;
 - f. ultrasonic;
- 15. Ambulance Service (Surface) or/and Ambulance Service (Air);
- 16. Orthopedic Appliances and prosthetics, not including replacements;
- 17. Prescription Drugs;
- 18. dental expense for sound natural teeth; and
- 19. other Medical Expenses as noted in the Schedule.

EXCLUSIONS (EXICS001-LA)

We will not pay benefits for a loss due to or expenses incurred for:

1. intentionally self-inflicted injury, suicide while sane or insane;
2. voluntary self-administration of a drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician;
3. treatment for alcoholism or drug addiction;
4. Injury caused by, attributable to, or resulting from the Insured's Intoxication;
5. Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
6. operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
7. operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred;
8. commitment of or an attempt to commit a felony, or engagement in an illegal activity;
9. participation in a riot or insurrection;
10. any Injury that results from fighting, brawling, assault or battery;
11. an act of declared or undeclared war;
12. active duty service in any Armed Forces;
13. operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the Insured Risk section of this policy;
14. mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
15. parachuting, except for self-preservation;
16. snow skiing, scuba diving, bob-sledding, bungee jumping, ballooning, flight in an ultralight aircraft, sky diving, hang-gliding, glider flying, sailplaning, or parasailing;
17. participation in professional or amateur racing;
18. sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning;
19. dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth;
20. orthodontic braces or appliances;
21. any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law;
22. treatment in any Veterans Administration or federal Hospital, unless there is a legal obligation to pay;
23. charges which the Insured would not have to pay if the Insured did not have insurance;
24. a charge which is in excess of the Allowable Expense;
25. cosmetic surgery, except reconstructive surgery due to a covered Injury;
26. participation in semi-professional and professional sports, play or practice, or any related travel;
27. participation in practice or play of any sports activity, including travel to and from, unless specified in this policy;
28. elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved;
29. mental and nervous disorders;
30. Pre-existing Conditions;
31. human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC);
32. infectious disease;
33. services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan;
34. services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited;
35. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any Other Insurance Plan;
36. any Accident in which the Insured is operating a motor vehicle without a current and valid motor vehicle operator's license (except in a driver's education program);
37. eyeglasses, contact lenses, hearing aids, or related examinations or prescriptions;
38. treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy.

TERMS OF BENEFIT PAYMENTS

We will pay the benefits specified in the DESCRIPTION OF BENEFITS section to all Insureds who suffer a loss within the Scope of Coverage due to Injury.

When an Other Insurance Plan denies benefits because the Insured failed to utilize, or chose not to use, an authorized medical vendor, We will pay the expense incurred that We would have paid in the absence of the Other Insurance Plan. The Insured must provide Us with such proof of denial.

FULL EXCESS MEDICAL EXPENSE (TBFE001)

We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period shown in the Schedule. We will determine the amount of benefits provided by any Other Insurance Plan without reference to any coordination of benefits, non-duplication of benefits or similar provisions. The amount of benefits provided by an Other Insurance Plan includes any amount to which the Insured is entitled whether or not a claim is made for the benefits. This Policy is secondary to all Other Insurance Plans.

The first Medical Expense must be incurred within the Loss Period stated in the Schedule.

The Maximum Benefit Amount payable and sub-limits under this policy are shown in the Schedule.

AIR ONLY AGGREGATE LIMIT OF LIABILITY (TBAGGLIM001)

The Air Only Aggregate Limit of Liability is shown in the Schedule. We will not be liable for any amount over this limit for any one air Accident. If the total amount of benefits to be paid to two or more Insureds is more than the Aggregate Limit of Liability, the benefit We will pay for each Insured's loss will be a proportionate share of the Aggregate Limit of Liability.

NON-DUPLICATION OF BENEFITS

This provision applies if an Insured:

- is covered by any Other Insurance Plan; and
- would, as a result, receive total medical expense or service benefits that would exceed the expenses actually incurred.

In this case, the Medical Expense for Accident Benefit payable under this policy will be reduced by the excess amount of benefits. The total amount of benefits payable will never exceed 100% of the Medical Expenses or service benefits.

CLAIM PROVISIONS

NOTICE OF CLAIM

We must receive written notice within 90 days after a loss occurs or begins, or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include:

- the Policyholder's name;
- the policy number; and
- the Insured's name and address.

CLAIM FORMS

When We receive the notice of the claim, We will send forms for filing proof of loss within 15 days. If We do not send the necessary forms within 15 days, written information may be given that includes the nature, date, cause, and extent of the loss for which claim is made.

PROOF OF LOSS

We must be given written proof of loss at Our home office or to Our authorized representative within 90 days after the date of the loss. If the written proof is not given within 90 days, the claim will not be invalidated or reduced if:

- it was not reasonably possible to give proof within 90 days; and
- proof is given as soon as reasonably possible, but not later than one year from the date it is otherwise required, except in the absence of legal capacity.

If the claim is for a continuing loss for which this policy provides periodic payments, written proof that the loss continues must be given to Us or to Our authorized representative at the intervals We require.

Physical Examination and Autopsy

We have the right to have an Insured examined at Our cost and as often as reasonably necessary while the claim is pending. We may require an autopsy at Our expense unless prohibited by law.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable proof of loss and confirm benefits are payable, but not later than 30 days after receipt of such proof or confirmation.

We will pay benefits for loss of life and any benefits payable to the Insured but unpaid at the Insured's death to the Insured's named beneficiary for this policy. This choice must be in writing and filed with Us, or filed with the Policyholder if We have agreed in advance.

The Insured has the right to change the beneficiary. Unless this right has been given up, the Insured does not need the consent of the beneficiary to make a change.

If the Insured has not named a beneficiary or no beneficiary survives the Insured, We will pay benefits at the Insured's death as follows:

- to the Insured's surviving spouse; if none, then
- in equal shares to the Insured's surviving children; if none, then
- in equal shares to the Insured's surviving parents; if none, then
- in equal shares to the Insured's surviving brothers and sisters; if none, then
- to the Insured's estate.

If benefits are payable to a person who is not legally competent to claim or release benefits, a minor, or an estate, We may pay up to \$1,000 to any relative by blood or marriage whom We find entitled to the payment. This good faith payment satisfies Our legal duty to the extent of the payment.

Assignment of Benefits

The Insured may direct that We pay benefits to a Hospital, Physician or other provider who furnished care, diagnosis, advice or supplies. We are not liable for any actions We take before We receive notice of the assignment. We are not responsible for the validity of any assignment of benefits.

OPPORTUNITY TO REQUEST AN APPEAL

The claimant may request an appeal, in writing, within 60 days after receiving notice of Our initial claim review decision.

The request for an appeal should include:

- the Policyholder's name and the Policy number or group number;
- the Insured's name and mailing address;
- the name and mailing address of the claimant filing the appeal, if different from the Insured;
- the nature of the appeal; and
- any additional information that may have been omitted from Our review or that We should consider.

By requesting an appeal, the claimant has authorized Us, or anyone We designate, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal. We will review all information submitted and make Our final determination. No additional appeals are available.

Applicable state laws may contain requirements for claims review and appeal procedures. To the extent that this provision is inconsistent with any state law requirement, the requirement that is most favorable to the claimant will apply.

AUTHORITY TO INTERPRET POLICY

By purchasing this policy, the Policyholder grants Us the discretion and the final authority to construe and interpret this policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any policy benefits within the terms of this policy as We interpret it. We will pay benefits under this policy only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured, or any other third party. Our interpretation of this policy as to the amount of benefits and eligibility will be binding and conclusive on all persons.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in this policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this policy.

PREMIUM PROVISIONS

REPORTING REQUIREMENTS

The Policyholder or its authorized agent must report to Us any additional information required, as We and the Policyholder agree. We must receive this report before the premium due date.

GRACE PERIOD

There is a 31-day grace period for payment of each premium due after the first premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period unless the Policyholder has notified Us of its intention to terminate this policy.

If We have not been notified otherwise and the premium has not been paid, this policy will end on the date premium was due.

CHANGES IN RATES

We have the right to change the premium rates:

- at any time there is a change in the coverage provided or classes eligible;
- at any time there is a change in the risks We have assumed; or
- after the first 12 months insurance is in effect.

New rates based on coverage or eligibility changes will take effect on the effective date of those changes. Otherwise, we will give 45 days written notice when we change the rates. Notice will be sent to the Policyholder's most recent address in Our records.

REINSTATEMENT AFTER TERMINATION

If this policy terminates for any reason, the Policyholder may request to reinstate it. We will reinstate only if:

- an authorized representative in Our home office agrees in writing to reinstate this policy;
- the Policyholder agrees in writing to accept any written conditions of reinstatement that We impose;
- all past due premiums are paid, including any premium for the time insurance was in effect during the grace period; and
- the premium due from the date of reinstatement until the next premium due date is paid.

GENERAL PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

- this policy;
- the attached Schedule;
- any riders or endorsements; and
- the application, if applicable.

Statements in an application are considered representations and not warranties. We will not use any statements in the Policyholder's application to deny a claim or to contest the validity of this insurance unless We provide the Policyholder, the Insured, the Insured's beneficiary or an authorized representative with a copy of that application.

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change, unless required by law. No one else has the authority to change the insurance contract. A change in the insurance contract must be:

- in writing;
- made a part of this policy; and
- signed by Our authorized representative in Our home office.

WORKERS COMPENSATION INSURANCE

This policy does not satisfy any requirement for coverage under any workers compensation law.

POLICYHOLDER RECORDS

The Policyholder or its authorized administrator will maintain records of the essential features of each Insured's insurance under this policy.

We have the right to examine the Policyholder's records relating to coverage under this policy. Examination may occur at any reasonable time up to the later of:

- two years after this policy ends; or
- the date of final adjustment and settlement of all claims under this policy.

REIMBURSEMENT/SUBROGATION

Applicability

If there is a conflict between the provisions of the Reimbursement/Subrogation section of the policy and the provisions of any Other Insurance Plan, the provisions that provide the greatest rights to Us and this policy govern.

Obligations of Insured

Relating to benefits covered by this policy, an Insured must:

- immediately notify Us of any potential causes of action or claims for a recovery that the Insured may have against a third party;
- notify Us of any agreement with a third party;
- provide Us with a copy of any summons, complaint, or other process served in any lawsuit in which the Insured seeks a recovery;
- provide Us with a copy of any agreement with a third party;
- immediately notify Us of any settlement offer regarding a potential recovery or any payment made pursuant to an agreement;
- obtain written consent from Us before entering into any agreement with a third party involving a potential recovery;
- cooperate and assist Us in enforcing Our subrogation and reimbursement rights;
- provide any information as may be requested by Us related to Our subrogation and reimbursement rights;
- assist Us in any action against any third party; and
- upon Our request, execute a subrogation agreement, assignment of recoveries, and/or reimbursement agreement in Our favor.

If a third party pays the Insured directly based on an agreement, the Insured must reimburse Us the amount of any payments We previously made to the Insured (or for which We may have future responsibility) with respect to Injury covered by this policy. The Insured must hold any recovery or payment (including amounts paid for future medical expenses) and any right of recovery against the third party in trust for Us.

An Insured may not take any action to prejudice Our rights under the policy.

Our Rights

We may:

- take action against any party (including, but not limited to, an attorney or trust) in possession of property or funds awarded or paid as a result of the Insured's Injury if such property or funds should be or should have been paid to Us under this Reimbursement/Subrogation section;
- seek a temporary restraining order against any party to prevent disbursement of any property or funds to which We have a right;
- seek restitution in equity (through the imposition of a constructive trust for Our benefit) from any party for the full amount of benefits paid by Us or for which We may have future responsibility;
- invoke equitable remedies as may be necessary to enforce the terms of the policy, including, but not limited to, specific performance, restitution and the imposition of an equitable lien and/or constructive trust, as well as injunctive relief;
- refuse to pay benefits to an Insured if the Insured fails to comply with this Reimbursement/Subrogation section, fails to cooperate with Us in regard to Our subrogation and reimbursement rights, or refuses to execute and deliver any papers that We may require in furtherance of Our subrogation and reimbursement rights;
- if the Insured fails to reimburse Us as provided in this Subrogation/Reimbursement section, offset any future benefits otherwise payable to or on behalf of the Insured, until the amount required to be reimbursed under the policy is fully offset;
- if the Insured receives a third party payment relating to expenses or benefits paid or payable by the policy, suspend all further benefit payments related to the Insured until the reimbursable portion is returned to Us or offset against amounts that would otherwise be paid to or on behalf of the Insured; and
- if an Insured fails or refuses to comply with this Reimbursement/Subrogation section, terminate the Insured's coverage.

We legally succeed the Insured's right of recovery against a third party up to the amount of benefits We have paid (or for which We may have future responsibility) with respect to the Insured's Injury. We have first priority on any money recovered from the third party, including, but not limited to, any amounts paid for medical costs over the uninsured or underinsured motorist's coverage, medical malpractice or any liability plan. Our contractual right to reimbursement is in addition to and separate from equitable subrogation. Our contractual right of reimbursement may be enforced under the same terms as discussed in this Reimbursement/Subrogation section.

If the Insured is a minor, We have no obligation to pay benefits related to Injury or Sickness caused by a third party until after the Insured's legal representative obtains valid court recognition and approval of Our 100%, first-dollar subrogation and reimbursement rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement of these rights.

If We file suit to enforce Our right to recover from the Insured, We reserve the right to be reimbursed for Our court costs and attorneys' fees in relation to the suit.

Priority; Other Legal Doctrines

If a third party makes any payment to the Insured, the Insured's attorney, or a trust for the Insured's benefit, the payment must first be used to provide equitable restitution to Us, to the full extent of expenses or benefits paid by or payable under the policy. Our priority applies despite other legal doctrines or theories. Our rights of subrogation and reimbursement under this Reimbursement/Subrogation section are not affected, reduced, or eliminated by the make-whole doctrine, the common fund doctrine, the doctrine of comparative fault theory, or any other legal doctrine or theory. We expressly reject the common fund doctrine with regard to attorneys' fees. Our rights are not affected, reduced, or eliminated by any allocation that purports to allocate recovery amounts in whole or in part to nonmedical damages.

POLICY TERMINATION

We may terminate this policy at any time. We will give at least 60 days notice before termination.

The Policyholder may terminate this policy at any time. If the Policyholder fails to pay premiums when due or within the grace period, We will consider notice to have been given to terminate this policy on the date premium was due.

Policy termination will not affect a claim for a loss due to an Accident that occurred while this policy was in effect.

CONFORMITY WITH STATE STATUTES

Any provision of this policy in conflict with the laws of the state where it is issued on the Policy Effective Date is amended to conform to the minimum requirements of such laws.

LEGAL ACTIONS

No legal action to recover under this policy can be brought for at least 60 days after We have been given written proof of loss. No legal action can be brought after one year from the time written proof of loss is required to be given to Us.

CERTIFICATES OF INSURANCE

We will deliver a certificate of insurance to the Policyholder for delivery to the Insured, in those states in which it is required. Each certificate will list the benefits, conditions, and limits of this policy.

EXTENSION OF TIME LIMITS

Any time limitation in the policy regarding giving notice of claim, furnishing proof of loss, or bringing any action on the policy which, on the policy's effective date, is less than the minimum time period permitted by the laws of the state in which the Insured resides on that date, is extended to conform to the minimum requirements of those laws.

DEFINITIONS

The following capitalized terms have the meaning assigned to them in this section. The assigned definitions apply to both the singular and plural forms of the defined term.

Accident means an unexpected and unintended event, independent of sickness and all other causes, which:

- causes Injury to an Insured; and
- occurs within the Scope of Coverage.

Ambulance Service (Air) means the service provided:

- by means of a fixed or roto-winged aircraft equipped with life support and medical apparatus; and
- for the primary purpose of transporting an Insured to or from the Hospital where treatment is given.

Ambulance Service (Surface) means the service provided:

- by a commercial or municipal ground ambulance service; and
- for transporting an Insured to or from the Hospital where treatment is given.

Allowable Expense means a Medical Expense otherwise payable under the policy that is not in excess of the 80th percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the policy. The Database will be updated by us as information becomes available from the supplier, up to twice each year. We may modify the Database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

Ambulatory Surgical Center means a surgical or medical center which:

- has permanent facilities for surgery;
- has an organized medical staff of Physicians and graduate registered nurses (R.N.);
- is authorized by law in the jurisdiction in which it is located to perform surgical services; and
- is licensed (if no license is required, officially approved) under the law.

Benefit Period means the period of time, as stated in the Schedule, from the date of the Injury within which benefits will be paid.

Controlled Substance means any drug or substance, other than alcohol, having the capacity to affect behavior and that is regulated by law with regard to possession and use.

Deductible (Aggregate) means the aggregate amount, as shown on the Schedule, of covered Medical Expenses, determined in accordance with the terms and conditions of this policy, that:

- are incurred in combination by one or more Insureds; and
- are incurred within the Benefit Period(s) for the covered Injuries.

Additionally, the Medical Deductible:

- can only be satisfied by payments made by or on behalf of the Policyholder and are subject to the Maximum Benefit Amount; and
- cannot be satisfied or reduced by any payment made under any Other Insurance Plan.

Deductible (Reducing) means the amount of eligible Medical Expenses incurred by an Insured for each loss before benefits are payable under this policy. Medical Expenses payable under any Other Insurance Plan will be used to satisfy or reduce this Deductible. It applies separately to each Insured and each Injury.

Durable Medical Equipment means equipment that is Medically Necessary, appropriate for the medical care of the Insured, and ordered by a Physician for the specific use of the Insured. It is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose and generally is not useful to an individual in the absence of an Injury.

Heart or Circulatory Malfunction means an acute onset of a cardiovascular or circulatory accident, stroke or other similar traumatic event affecting the heart or circulatory system:

- which is first diagnosed and treated while the Insured's coverage under this policy is in force;
- which occurs as a result of Injury to the Insured while participating in a Sponsored or Supervised Activity; and
- which does not result from a Pre-Existing Condition.

Hospital means an institution which:

- is operated pursuant to law;
- is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
- is under the supervision of a staff of Physicians;
- provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.); and
- has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available to it on a prearranged basis.

Hospital does not include:

- a clinic or facility for:
 - convalescent, custodial, educational or nursing care;
 - the aged, drug addicts or alcoholics;
 - rehabilitation; or
- a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
 - the services are rendered on an emergency basis; and
 - the individual has a legal liability to pay for the services given in the absence of insurance.

Immediate Family Member means a spouse or a child, parent, grandparent, brother or sister of the Insured, step-relatives in these same categories, or a person who reared the Insured, or a person whom the Insured reared.

Injury means bodily harm which:

- requires treatment by a Physician;
- results in loss due to an Accident, independent of sickness and all other causes; and
- occurs within the Scope of Coverage.

For this purpose, bodily harm includes:

- wear and tear (loss and damage caused by overuse) of an Insured's body part; and
- re-injury or aggravation of an injury sustained prior to the effective date of the Insured's coverage under this policy if:
 - the Insured was given medical clearance to participate in the appropriate Sponsored or Supervised Activity of the Policyholder by the Physician responsible to the Policyholder for such determination; and
 - such re-injury or aggravation occurs within the Scope of Coverage.

Bodily harm does not include a Pre-Existing Condition except in the case of re-injury or aggravation of an injury as provided in this definition.

Insured means a person:

- who is eligible for insurance under the terms of the policy; and
- for whom proper premium has been paid.

Intensive Care Unit means a section, ward, or wing within a Hospital which is separated from other Hospital facilities and:

- is operated exclusively for the purpose of providing professional treatment for critically ill or Injured patients;
- has special supplies and equipment necessary for such treatment which is available on a standby basis for immediate use;
- provides room and board, and constant observation by registered graduate nurses or other specialty trained Hospital personnel; and
- is not maintained for the purpose of providing normal post-operative recovery treatment or service.

Intoxicated, intoxication means the Insured's condition as determined and defined by the laws in the jurisdiction in which the loss or cause of loss was incurred; (for the purposes of this exception, the laws governing the operation of motor vehicles while intoxicated will apply to any activity occurring at the time of the accident.)

Laboratory Tests means laboratory procedures identified in Physician Current Procedural Terminology (CPT) as codes 80000- 89999 inclusive.

Loss of a Foot means Severance above the ankle.

Loss of a Hand means Severance at or above the wrist.

Loss of Hearing means total and permanent loss of hearing which cannot be corrected by any means.

Loss of Sight means the total, permanent loss of sight of the eye or eyes. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total, permanent and irrecoverable loss of audible communication.

Loss of a Thumb and Index Finger of the same hand means Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand) from the same Accident.

Loss Period means the period of time stated in the Schedule from the date of an Accident within which the Insured must seek initial treatment for an Injury or death or Specific Loss must occur.

Maximum Benefit Amount means the total benefits payable under an applicable benefit provision. The Maximum Benefit Amount is shown in the Schedule.

Medical Expenses means expenses incurred for Medically Necessary services and supplies. Medical Expenses are incurred on the date the service or supply is rendered or provided.

Medically Necessary, Medical Necessity means care that is ordered, prescribed, or rendered by a Physician or Hospital, and is determined by Us, or a qualified party or entity selected by Us, to be:

- consistent with the diagnosis and treatment of the loss;
- appropriate with the standards of good medical practice;
- not solely for the convenience of the Insured;
- the most appropriate supply or level of service which can be safely provided; and
- not considered experimental or investigative.

Nurse means a professional, licensed, graduate registered nurse (RN), a professional, licensed practical nurse (LPN) or a certified registered nurse anesthetist (CRNA).

Nurse Practitioner means a licensed registered nurse who has received special training for diagnosing and treating routine or minor ailments.

Off-season Physical Conditioning means a physical conditioning activity that is

- not the play or practice of the insured sport;
- officially sanctioned by the Policyholder; and
- scheduled and supervised by a regularly employed coach or trainer.

Orthopedic Appliances means braces and appliances that:

- are prescribed by a Physician;
- are primarily and customarily used to serve a medical purpose;
- can withstand repeated use; and
- are Medically Necessary.

Other Insurance Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- any individual, group, blanket, or franchise policy of accident, disability, or health insurance;
- any arrangement of benefits for members of a group, whether insured or uninsured;
- any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations;
- any amount payable for Hospital, medical, or other health services for Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy;
- any amount payable for services for injuries or diseases related to the Insured's job to the extent that the Insured actually receives benefits under a workers compensation law. If the Insured enters into a settlement to give up the Insured's rights to recover future medical expenses under a workers compensation law, this policy will not pay those medical expenses that would have been payable except for that settlement; or
- any benefits payable under any program provided or sponsored solely or primarily by any federal, state, or local governmental unit or agency or subdivision or through operation of law or regulation, except Medicaid and Tricare.

Outpatient Surgical Center means a surgical, or medical center which has:

- permanent facilities for surgery;
- organized medical staff of Physicians and Nurses; and
- is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Physician means a legally qualified physician or state licensed Nurse Practitioner, Physician's Assistant, dentist, osteopath, optometrist, chiropractor, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, licensed clinical social worker, or licensed professional counselor practicing within the scope of his or her license; and recognized as a physician in the state where services are rendered. Physician does not include:

- the Insured; or
- an Immediate Family Member; or
- a person living with the Insured; or
- a person employed or retained by the Policyholder.

Physician's Assistant (PA) means a medical professional, other than the Insured, who is trained and licensed to provide basic medical services under the direction of a Physician.

Pre-Existing Condition means any condition for which an Insured has received care, diagnosis or advice from a Physician or of which symptoms were manifested within 12 months before being covered by this policy.

Prescription Drugs means drugs which:

- under Federal law may only be dispensed by written prescription; and
- are approved for general use by the Food and Drug Administration.

Scope of Coverage means insurance coverage limited to a loss which:

- is within the scope of the risks specified in the INSURED RISKS section of this policy;
- is specified in the DESCRIPTION OF BENEFITS section of this policy;
- occurs during the Loss Period for the loss incurred specified in the Schedule, if any; and
- occurs while this policy is in effect.

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

Sponsored or Supervised Activity means a Policyholder authorized function:

- in which the Insured participates;
- which is organized by or under its auspices and sanctioned by the appropriate governing authority; and
- which is within the scope of customary activities for such entity.

We, Our, Us means Mutual of Omaha Insurance Company.

X-ray means those procedures identified in Physician Current Procedural Terminology (CPT) as codes 70000-79999 inclusive.

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

Mutual of Omaha Insurance Company

Home Office:

**3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175**

**SUMMARY OF THE LOUISIANA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION LAW 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 required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA 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 happens, LLHIGA will assess its other member insurance companies for the money to pay the 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 LLHIGA is limited. As noted in the disclaimer 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 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 generally 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. Box 3337
Baton Rouge, LA 70821

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

The state law that provides for the safety-net coverage is the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 *et seq.* The following is a brief summary of this law's coverages, 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 law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

- (1) He is 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) His policy was issued by a profit or 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, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA 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 or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- (4) Dividends, premium refunds, or similar fees or allowances described under the Law;
- (5) Credits given in connection with the administration of a policy by a group contract holder;
- (6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); or uninsured
- (7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b));
- (8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
- (9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
- (10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNT OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

- (1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
- (2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
- (3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.

Attachment C

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following page is an example of the University's Athlete Medical Referral Form.

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
- Ruston Eye and Vision
- Smith Chiropractic
- Other



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

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.

Student Athlete does not have primary insurance or is out of network, please submit bills directly to AG Administrators for payment.

Bill Louisiana Tech Industrial Account

Louisiana Tech Athletics is not responsible for this visit, all payment requests should be sent to student athlete

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 _____

Attachment D

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following pages provide Claims History by Year.

Program Data

Paid Claims as of May 31, 2026

| Year | Aggregate Deductible | Stop Loss Premium | Administrative Fees | Paid Accident/Injury Claims | Paid Discretionary General Medical Claims |
|------------------|----------------------|-------------------|---------------------|-----------------------------|---|
| 2021-2022 | \$351,000 | \$30,000 | \$45,000 | \$455,321 | \$274,088 |
| 2022-2023 | \$368,000 | \$31,500 | \$45,000 | \$578,109 | \$94,752 |
| 2023-2024 | \$385,000 | \$27,600 | \$37,500 | \$528,374 | \$114,562 |
| 2024-2025 | \$500,000 | \$39,299 | \$47,500 | \$314,233 | \$57,491 |
| 2025-2026 | \$500,000 | \$36,999 | \$35,000 | \$85,162 | \$26,304 |

Attachment E

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following pages provide the current University Sports Census information.

Census

Intercollegiate Sport Census

| Sport | Men | Women |
|---------------|------------|-------|
| Baseball | 34 | 0 |
| Basketball | 15 | 15 |
| Bowling | 0 | 11 |
| Cheerleading | | |
| Cross Country | 6 | 6 |
| Football | 105 | 0 |
| Golf | 9 | 0 |
| Soccer | 0 | 28 |
| Softball | 0 | 25 |
| Tennis | 0 | 10 |
| Track & Field | 30 | 40 |
| Volleyball | 0 | 18 |
| Totals | 352 | |

Breakdown of Student-Athletes by Age Range

| | |
|--------------|------|
| 22 and under | 319 |
| 23-26 | 68 |
| 27 and over | none |

Attachment F

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following pages provide Brochure for current Component #2 plan.

H &W Indemnity (SPC), Ltd. for and on behalf of Student Resources SP
Governors Square, Building 4, 2nd Floor, 23 Lime Tree Bay Avenue
P.O. Box 1051, Grand Cayman, Cayman Islands

INTERNATIONAL STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

GLOBAL CARE INTERCOLLEGIATE SPORTS PLUS PLAN (International Students)

Designed Exclusively for International Students

Issued to:

ITA Global Trust Ltd. as Trustee of the International Student Health and Wellness Trust

2025-2026

This Certificate of Coverage is Part of Policy # 2025-202965-91

This Certificate of Coverage ("Certificate") is part of the contract between H & W Indemnity (SPC), Ltd. for and on behalf of Student Resources SP (hereinafter referred to as the "Company," "We," "Us," and "Our") and the Policyholder.

Please keep this Certificate as an explanation of the benefits available to the Insured Person under the contract between the Company and the Policyholder. This Certificate is not a contract between the Insured Person and the Company. Amendments or endorsements may be delivered with the Certificate or added thereafter. The Master Policy is on file with the Policyholder and contains all of the provisions, limitations, exclusions, and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

Underwritten by: H & W Indemnity (SPC), Ltd.
for and on behalf of Student Resources SP
A UnitedHealth Group Company
Administered by:
UnitedHealthcare Student Resources International

Table of Contents

| | |
|---|------------|
| Introduction..... | 1 |
| Section 1: Who Is Covered | 1 |
| Section 2: Effective and Termination Dates..... | 1 |
| Section 3: Extension of Benefits after Termination | 2 |
| Section 4: Pre-Admission Notification | 2 |
| Section 5: Preferred Provider and Out-of-Network Provider Information | 2 |
| Section 6: Medical Expense Benefits..... | 3 |
| Section 7: Additional Benefits | 8 |
| Section 8: Excess Provision..... | 9 |
| Section 9: Accidental Death and Dismemberment Benefits | 9 |
| Section 10: Definitions | 9 |
| Section 11: Exclusions and Limitations..... | 14 |
| Section 12: How to File a Claim for Injury and Sickness Benefits | 16 |
| Section 13: General Provisions..... | 16 |
| Section 14: Online Access to Account Information | 17 |
| Section 15: ID Cards | 17 |
| Section 16: UHCSR Mobile App | 17 |
| Section 17: Important Company Contact Information | 17 |
| Additional Policy Documents | |
| Schedule of Benefits | Attachment |
| Intercollegiate Sports Coverage Endorsement | Attachment |
| Pediatric Dental Services Benefits | Attachment |
| Pediatric Vision Services Benefits | Attachment |
| UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits | Attachment |
| Assistance and Evacuation Benefits..... | Attachment |

Introduction

Welcome to the UnitedHealthcare Student Resources International Student Health Insurance Plan ("Plan"). The Plan is underwritten by H & W Indemnity (SPC), Ltd. for and on behalf of Student Resources SP.

The Company will provide the benefits described in this Certificate to Insured Persons, as defined in the Definitions section of this Certificate. This Certificate is not a contract between the Insured Person and the Company. Keep this Certificate with other important papers so that it is available for future reference.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-888-251-6253. The Insured can also write to the Company administrator at:

UnitedHealthcare Student Resources International
Email: international@uhcsr.com

Section 1: Who Is Covered

The Master Policy covers students and their eligible Dependents who have met the Policy's eligibility requirements (as shown below) and who:

1. Are properly enrolled in the Plan, and
2. Pay the required premium.

International students or other persons with a current passport who: 1) are engaged in educational activities; 2) are temporarily located outside his/her home country as a non-resident alien; 3) have not obtained permanent residency status in the U.S.; and 4) are enrolled in an associate, bachelor, master or Ph.D. degree program at a university or other educational institution, with no less than 6 credit hours (unless such school's full-time status requires less); Visiting Scholars with an F1 or J1 visa are eligible to enroll in this insurance Plan. The six credit hour requirement is waived for Summer if the applicant was enrolled in this plan as a full-time student in the immediately preceding Spring term.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

The student (Named Insured, as defined in this Certificate) must actively attend classes for at least the first 31 days after the date for which coverage is purchased with the exception of International Visiting Scholars. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
 - a. On the date the Named Insured acquires a legal spouse.
 - b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

U.S. citizens and residents are not eligible for coverage as a student or Dependent.

Section 2: Effective and Termination Dates

The Master Policy issued to the Policyholder becomes effective at 12:01 a.m., July 1, 2025. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., September 30, 2026. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Twelve (12) months is the maximum time coverage can be effective under any Policy Year for any Insured Person. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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.uhcsr.com/myaccount. 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.

A provider's status may change. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling Customer Service at 1-888-251-6253 and/or by asking the provider when making an appointment for services. A directory of providers is available on the Plan's website at www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information).

If an Insured receives a Covered Medical Expense from an Out-of-Network Provider and was informed incorrectly by the Company prior to receipt of the Covered Medical Expense that the provider was a Preferred Provider, either through Our provider directory or in Our response to the Insured's request for such information (via telephone, electronic, web-based or internet-based means), the Insured may be eligible for cost-sharing (Copayment, Coinsurance, and applicable Deductible) that would be no greater than if the service had been provided from a Preferred Provider.

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-888-251-6253 to find out if they are eligible for continuity of care benefits.

The Company will pay Covered Medical Expenses according to the benefits set forth in the Schedule of Benefits. Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid.

Allowed Amounts are the amounts the Company will pay for Covered Medical Expenses. Refer to the definition of Allowed Amount in this Certificate for information on how the Company determines Allowed Amounts.

Preferred Provider Benefits

The Insured is not responsible for any difference between what the Company pays for Allowed Amounts and the amount the provider bills, except for the Insured Person's cost share obligation as specified in the Schedule of Benefits.

Out-of-Network Provider Benefits

The Insured is responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills the Insured and the amount the Company pays for Allowed Amounts.

Section 6: Medical Expense Benefits

This section describes Covered Medical Expenses for which benefits are available. **Please refer to the attached Schedule of Benefits for benefit details.**

Benefits are payable for Covered Medical Expenses (see Definitions) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Policy Maximum Benefit as set forth in the Schedule of Benefits; b) the maximum amount for specific services as set forth in the Schedule of Benefits; and c) any Coinsurance or Copayment amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section.

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

Inpatient

1. **Room and Board Expense.**

Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **Intensive Care.**

See Schedule of Benefits.

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.

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.
12. **Day Surgery Miscellaneous.**
Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery, if provided in the Schedule of Benefits.
14. **Anesthetist Services.**
Professional services administered in connection with outpatient surgery.
15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.

Physician's Visits for preventive care are provided as specified under Preventive Care Services.
16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
 - Physical therapy.
 - Occupational therapy.
 - Cardiac rehabilitation therapy.
 - Manipulative treatment.
 - Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, Congenital Condition, or vocal nodules.
17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
 - Facility charge for use of the emergency room and supplies.
All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services.**
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy.**
See Schedule of Benefits.
20. **Laboratory Procedures.**
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
21. **Tests and Procedures.**
Tests and Procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
 - Physician's Visits.
 - Physiotherapy.
 - X-rays.
 - Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:

- Inhalation therapy.
- Intravenous infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis, hemodialysis, and peritoneal dialysis.

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.

30. Substance Use Disorder 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.

31. Maternity.

If provided in the Schedule of Benefits.

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 mother earlier than these minimum time frames.

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

32. Complications of Pregnancy.

See Schedule of Benefits.

33. Preventive Care Services.

Benefits are limited to medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and that are specified in the Company's guidelines for preventive care services.

Company guidelines for preventive care services are based on the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

34. Reconstructive Breast Surgery Following Mastectomy.

Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and physical complications of mastectomy, including lymphedemas.

35. Diabetes Services.

Same as any other Sickness in connection with the treatment of diabetes.

Benefits will be paid for Medically Necessary:

- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Medical eye exams (dilated retinal exams).
- Preventive foot care for diabetes.
- Prescription Drugs, equipment, and supplies based on the Insured's specific medical needs, including:
 - Insulin pumps and supplies.
 - Blood glucose meters including continuous glucose monitors.
 - Insulin syringes with needles.
 - Blood glucose and urine test strips.
 - Ketone test strips and tablets.
 - Lancets and lancet devices.

36. High Cost Procedures.

The following procedures provided on an outpatient basis:

- CT Scan.
- PET Scan.
- Magnetic Resonance Imaging.

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.

BENEFITS FOR DENTAL ANESTHESIA

Benefits will be provided for dental anesthesia and related Hospital Covered Medical Expenses for services and supplies provided to a covered Insured Person who is either:

- A child under age five.
- Severely disabled or otherwise suffers from a developmental disability as determined by a Physician which places a child at serious risk.

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

Section 8: Excess Provision

Even if you have other insurance, the plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance.

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or, under an automobile insurance policy.

However, this Excess Provision will not be applied to the first \$100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with Policy provisions or requirements.

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If an accidental Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below.

Payment under this benefit when added to payment under the Medical Expense Benefits shall not exceed the Policy Maximum Benefit.

For Loss Of:

| | |
|-----------------------|------------|
| Life | \$5,000.00 |
| Two or More Members | \$5,000.00 |
| One Member | \$2,500.00 |
| Thumb or Index Finger | \$1,250.00 |

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Section 10: Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under the Policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

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 with activities of daily living, including eating, dressing, bathing, transferring, and ambulating.
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.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to the Policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

DEPENDENT means the legal spouse of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the enrollment period in which they attain the age of 26 years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
2. Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the Policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Company has the right to seek expert opinion in determining whether services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use such expert opinion shall be determined by the Company.

The Company develops and maintains clinical policies that describe the generally accepted standards of medical practice scientific evidence, prevailing medical standards, and clinical guidelines supporting the Company's determinations regarding specific services. These clinical policies are available through UHCprovider.com.

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.

Habilitative services do not include Elective Surgery or Elective Treatment or services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

HOSPITAL means a licensed or properly accredited general hospital which is all of the following:

1. Open at all times.
2. Operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients.;
3. Under the supervision of a staff of one or more legally qualified Physicians available at all times.

4. Continuously provides on the premises 24 hour nursing service by Registered Nurses.
5. Provides organized facilities for diagnosis and major surgery on the premises.
6. Not primarily a clinic, nursing, rest or convalescent home.

For the purpose of Mental Illness or Substance Use Disorder treatment, the surgery requirement does not apply.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is all of the following:

1. Directly and independently caused by specific accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician within 30 days after the date of accident.
5. Sustained while the Insured Person is covered under the Policy.

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 Generally Accepted Standards of Medical Practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most clinically appropriate supply, frequency, duration, 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 Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders published by 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.

NAMED INSURED means an eligible participant of the participating institution of higher education if: 1) the participant is properly enrolled in the Policy; and 2) the appropriate premium for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

OUT-OF-NETWORK PROVIDER means a provider who does not have a contract with the Company to provide services to Insured Persons.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Not all Policies have an Out-of-Pocket Maximum. Refer to the Policy Schedule of Benefits to determine if this Policy has an Out-of-Pocket Maximum and for details on how the out-of-pocket maximum applies.

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

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

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

POLICY OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

POLICY YEAR means the period of time beginning on the Policy Effective Date and ending on the Policy Termination Date.

POLICYHOLDER means the entity to whom the Master Policy is issued.

PREFERRED PROVIDER means a provider that has a participation agreement in effect (either directly or indirectly) with the Company or Our affiliates to participate in Our preferred provider network. Our affiliates are those entities affiliated with the Company through common ownership or control with Us or with Our ultimate corporate parent, including direct and indirect subsidiaries.

PRESCRIPTION DRUGS means any of the following:

1. Prescription legend drugs.
2. Compound medications of which at least one ingredient is a prescription legend drug.
3. Any other drugs which under the applicable law may be dispensed only upon written prescription of a Physician.
4. Injectable insulin.

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

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under the Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. 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.

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 Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders published by 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 an entity 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.
19. Investigational services.
20. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
21. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
 - Immunization agents, except as specifically provided in the Policy. Biological sera. Blood or blood products administered on an outpatient basis.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
22. Reproductive services for the following:
 - Procreative counseling.
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the Policy.
 - Vasectomy.
 - Sexual reassignment surgery.
 - Reversal of sterilization procedures.
23. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study.
24. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. This exclusion does not apply as follows:
 - When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
25. Routine Newborn Infant Care, and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
26. Preventive care services. Routine physical examinations and routine testing. Preventive testing or treatment. Screening exams or testing in the absence of Injury or Sickness. This exclusion does not apply to benefits specifically provided in the Policy.

27. Services provided normally without charge by the Health Service of the institution attended by the Insured or services covered or provided by a student health fee.
28. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
29. Speech therapy, except as specifically provided in the Policy.
30. Supplies, except as specifically provided in the Policy.
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Policy.
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
33. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
34. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Section 12: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Center or Infirmary or when not in school, to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/myaccount. A Company claim form is not required for filing a claim.
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.

If submitting a claim by mail, send the above information to the Company at:

UnitedHealthcare Student Resources International
P.O. Box 809025
Dallas, TX 75380-9025

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.

Section 14: Online Access to Account Information

UnitedHealthcare Student Resources International Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to My Account at www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information). Insured students who don't already have an online account may simply select the "Create Account" link. Follow the simple, onscreen directions to establish an online account in minutes using the Insured's 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare Student Resources International's environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes a message center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. Notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Profile and making the change there.

Section 15: ID Cards

Digital ID cards will be made available to each Insured Person. The Company will send an email notification when the digital ID card is available to be downloaded from My Account. An Insured Person may also use My Account to request delivery of a permanent ID card through the mail.

Section 16: UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or the App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.
- Find My Claims – view claims received within the past 120 days for both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.

Section 17: Important Company Contact Information

The Policy is Underwritten by:

**H & W Indemnity (SPC), Ltd. for and on behalf of Student Resources SP
Governors Square, Building 4, 2nd Floor
23 Lime Tree Bay Avenue
P.O. Box 1051
Grand Cayman, Cayman Islands**

Administrative Office:

UnitedHealthcare Student Resources International

1-888-251-6253

Website: www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information).

STUDENT ONLY - Schedule of Benefits

ITA GLOBAL TRUST LTD - GLOBAL CARE INTERCOLLEGIATE SPORTS PLUS
2025-202965-91

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 |

| Inpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|------------------------------------|---|
| Routine Newborn Care | Paid as any other Sickness | Paid as any other Sickness |
| 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 |
| Assistant Surgeon Fees 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 |
| Anesthetist Services | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Registered Nurse's Services | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Physician's Visits | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Pre-admission Testing Payable within 7 working days prior to admission. | Allowed Amount after Deductible | Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|--|---|
| 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 |
| Day Surgery Miscellaneous | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Assistant Surgeon Fees 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 |
| Anesthetist Services | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Physician's Visits | \$30 Copay per visit Allowed Amount not subject to Deductible | Allowed Amount after Deductible |
| Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. | \$30 Copay per visit Allowed Amount not subject to Deductible | Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|---|--|
| 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 |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| Elective Abortion \$1,500 maximum per Policy Year | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. | 100% of Allowed Amount not subject to Deductible | No Benefits |
| Reconstructive Breast Surgery Following Mastectomy | Paid as any other Sickness | Paid as any other Sickness |
| Diabetes Services | Paid as any other Sickness | Paid as any other Sickness |
| High Cost Procedures | \$200 Copay per visit Allowed Amount not subject to Deductible | \$200 Copay per visit Allowed Amount not subject to Deductible |
| Urgent Care Center | \$50 Copay per visit Allowed Amount not subject to Deductible | \$50 Copay per visit Allowed Amount not subject to Deductible |
| Hospital Outpatient Facility or Clinic | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Transplantation Services | Paid as any other Sickness | Paid as any other Sickness |
| Pediatric Dental and Vision Services | See endorsements attached for Pediatric Dental and Vision Services benefits | See endorsements attached for Pediatric Dental and Vision Services benefits |
| Intercollegiate Sports Injury \$10,000 maximum for each Injury See Intercollegiate Sports Coverage endorsement attached. | Paid as any other Injury | Paid as any other Injury |
| Titers Benefits are limited to titers related to immunizations for the following: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, MMR, Hep B, Hep A, Tdap, and Rubella. | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Tuberculosis Screening and Testing Benefits are limited to TB Screening and testing not covered under the Preventive Care Services Benefit. | 100% of Allowed Amount after Deductible | Allowed Amount after Deductible |

DEPENDENT ONLY - Schedule of Benefits

ITA GLOBAL TRUST LTD - GLOBAL CARE INTERCOLLEGIATE SPORTS PLUS
2025-202965-91
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. 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.

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 | Allowed Amount after Deductible | Allowed Amount after Deductible |

| Inpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|------------------------------------|---|
| the second procedure and 50% of all subsequent procedures. | | |

| Inpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|------------------------------------|---|
| Assistant Surgeon Fees 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 |
| Anesthetist Services | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Registered Nurse's Services | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Physician's Visits \$50 maximum per visit 30 visits maximum per Policy Year | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Pre-admission Testing Payable within 7 working days prior to admission. | Allowed Amount after Deductible | Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|--|--|
| 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 |
| Day Surgery Miscellaneous | \$100 Copay per date of service 80% of Allowed Amount not subject to Deductible | \$100 Copay per date of service 70% of Allowed Amount not subject to Deductible |
| Assistant Surgeon Fees 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 |
| Anesthetist Services | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Physician's Visits | \$50 maximum per visit Allowed Amount after Deductible | \$30 maximum per visit Allowed Amount after Deductible |
| Physiotherapy \$50 maximum per visit 12 visits maximum per Policy Year | Allowed Amount after Deductible | Allowed Amount after Deductible |
| 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. | \$200 Copay per visit 80% of Allowed Amount not subject to Deductible | \$200 Copay per visit 80% of Allowed Amount not subject to Deductible |
| Diagnostic X-ray Services | Allowed Amount | Allowed Amount |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|---|---|
| | after Deductible | 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 |
| 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 |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| Complications of Pregnancy \$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 |
| Elective Abortion \$1,500 maximum per Policy Year | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Preventive Care Services \$1,000 maximum per Policy Year No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. | 100% of Allowed Amount not subject to Deductible | No Benefits |
| Reconstructive Breast Surgery Following Mastectomy | Paid as any other Sickness | Paid as any other Sickness |
| Diabetes Services | Paid as any other Sickness | Paid as any other Sickness |
| High Cost Procedures | \$200 Copay per visit 80% of Allowed Amount not subject to Deductible | \$200 Copay per visit 70% of Allowed Amount not subject to Deductible |
| Urgent Care Center | \$50 Copay per visit 80% of Allowed Amount not subject to Deductible | \$50 Copay per visit 70% of Allowed Amount not subject to Deductible |
| Hospital Outpatient Facility or Clinic | Allowed Amount after Deductible | Allowed Amount after Deductible |
| Transplantation Services \$10,000 maximum per Policy Year | Paid as any other Sickness | Paid as any other Sickness |
| Pediatric Dental and Vision Services | See endorsements attached for Pediatric Dental and Vision Services benefits | See endorsements attached for Pediatric Dental and Vision Services benefits |
| Intercollegiate Sports Injury | No Benefits | No Benefits |
| Congenital Conditions \$20,000 maximum per Policy Year | Allowed Amount after Deductible | Allowed Amount after Deductible |

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:

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.

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:

Pediatric Dental Services Benefits

Benefits are provided under this endorsement for Covered Dental Services, as described below, for Insured Persons under the age of 19. Benefits under this endorsement terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the Policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

Network Benefits - these benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from an out-of-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured Person must obtain all Covered Dental Services directly from or through a Network Dental Provider.

Insured Persons must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. The Insured Person can check the participation status by calling the Company and/or the provider. The Company can help in referring the Insured Person to Network Dental Providers.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call the Company at the number stated on their identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an Out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an Out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from Out-of-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

The Insured Person is eligible for benefits for Covered Dental Services listed in this endorsement if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this endorsement.

What Is a Pre-Treatment Estimate?

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

Dental Services Deductibles are calculated on a Policy Year basis.

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.

Benefit Description

| 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 |
| Diagnostic Services - (Subject to payment of the Dental Services Deductible.) | | |
| <p><i>Evaluations (Checkup Exams)</i></p> <p>Limited to two times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.</p> <p>D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient D0160 - Detailed and extensive oral evaluation - problem focused, by report</p> | 50% | 50% |
| <p><i>Intraoral Radiographs (X-ray)</i></p> <p>Limited to one series of films per 36 months.</p> <p>D0210 - Intraoral comprehensive series of radiographic images D0709 - Intraoral - comprehensive series of radiographic images - image capture only D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only</p> | 50% | 50% |
| <p>The following services are limited to two per 12 months.</p> <p>D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image</p> | 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 |
| D0240 - Intraoral - occlusal radiographic image D0374 - Intraoral tomosynthesis - periapical radiographic image D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only | | |
| Any combination of the following services is limited to two series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only D0708 - Intraoral - bitewing radiographic image - image capture only | 50% | 50% |
| Limited to one time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only | 50% | 50% |
| The following service is limited to two 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% |

| 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 |
| Preventive Services - (Subject to payment of the Dental Services Deductible.) | | |
| <i>Dental Prophylaxis (Cleanings)</i> The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child | 50% | 50% |
| <i>Fluoride Treatments</i> The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish | 50% | 50% |
| <i>Sealants (Protective Coating)</i> The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth | 50% | 50% |
| <i>Space Maintainers (Spacers)</i> The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular | 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 |
| D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant | | |
| Minor Restorative Services - (Subject to payment of the Dental Services Deductible.) | | |
| <i>Amalgam Restorations (Silver Fillings)</i> The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent | 50% | 50% |
| <i>Composite Resin Restorations (Tooth Colored Fillings)</i> 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 (anterior) D2989 - Excavation of a tooth resulting in the determination of non-restorability | 50% | 50% |
| Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are subject to a limit of one 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 | 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 |
| 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 D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown | | |
| The following service is not subject to a frequency limit. D2940 - Protective restoration | 50% | 50% |
| The following services are limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins when required D2951 - Pin retention - per tooth, in addition to restoration | 50% | 50% |
| The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown | 50% | 50% |
| The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure | 50% | 50% |
| Endodontics - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration) D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) | 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 |
| D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | | |
| The following services are not subject to a frequency limit. 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 - premolar D3348 - Retreatment of previous root canal therapy - molar | 50% | 50% |
| 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. | 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 |
| D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy | | |
| Periodontics - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | 50% | 50% |
| The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue | 50% | 50% |
| The following services are limited to one every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - retained natural tooth - first site in quadrant D4286 - Removal of non-resorbable barrier | 50% | 50% |
| The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure | 50% | 50% |
| The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant | 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 |
| D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure - each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns | | |
| The following services are limited to onetime 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 one per lifetime. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | 50% | 50% |
| The following service is limited to four 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 one 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) | 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 |
| <p>D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)</p> <p>D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)</p> <p>D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)</p> <p>D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)</p> <p>D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth)</p> <p>D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth)</p> <p>D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary</p> <p>D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular</p> <p>D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant</p> <p>D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant</p> | | |
| <p>The following services are not subject to a frequency limit.</p> <p>D5410 - Adjust complete denture - maxillary</p> <p>D5411 - Adjust complete denture - mandibular</p> <p>D5421 - Adjust partial denture - maxillary</p> <p>D5422 - Adjust partial denture - mandibular</p> <p>D5511 - Repair broken complete denture base - mandibular</p> <p>D5512 - Repair broken complete denture base - maxillary</p> <p>D5520 - Replace missing or broken teeth - complete denture (each</p> | 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 |
| tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth 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 six months after the initial insertion with a frequency limitation of one 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. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular) | 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 |
| 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 D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic | 50% | 50% |
| The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis | 50% | 50% |
| The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal | 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 |
| D6930 - Re-cement or re-bond FPD D6980 - FPD repair necessitated by restorative material failure | | |
| Oral Surgery - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including 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, impacted teeth only | 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 or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 50% | 50% |
| The following service is 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 |
| D7471 - Removal of lateral exostosis (maxilla or mandible) | | |
| The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva | 50% | 50% |
| The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site | 50% | 50% |
| Adjunctive Services - (Subject to payment of the Dental Services Deductible.) | | |
| The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain - per visit | 50% | 50% |
| Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration | 50% | 50% |
| Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment) | 50% | 50% |
| The following services are limited to one guard every 12 months. | 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 |
| D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch | | |
| Implant Procedures - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are limited to onetime every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: 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) | 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 |
| 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 D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6089 - Accessing and retorquing loose implant screw per screw D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body | | |

| 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 |
| D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6105 - Removal of implant body not requiring bone removal nor flap elevation D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary 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 D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant | | |
| The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant | 50% | 50% |
| 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. All orthodontic treatment must be prior authorized. | | |

| 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 |
| 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. | | |
| 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 D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular | 50% | 50% |

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this endorsement under Section 2: Benefits for Covered Dental Services, benefits are not provided under this endorsement for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.

8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
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.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the Policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dental Services Deductible - the amount the Insured Person must pay for Covered Dental Services in a Policy Year before the Company will begin paying for Network or Out-of-Network Benefits in that Policy Year.

Experimental, Investigational, or Unproven Service - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- 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; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

Foreign Services - services provided outside the U.S. and U.S. Territories.

Necessary - Dental Services and supplies under this endorsement which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - For treating a life threatening dental disease or condition.
 - Provided in a clinically controlled research setting.
 - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - a group of Dental Providers who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Insured Persons. The participation status of providers will change from time to time.

Network Benefits - benefits available for Covered Dental Services when provided by a Dental Provider who is a Network Dentist.

Out-of-Network Benefits - benefits available for Covered Dental Services obtained from out-of-Network Dentists.

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

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.

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 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:

Pediatric Vision Care Services Benefits

Benefits are provided under this endorsement for Vision Care Services, as described below, for Insured Persons under the age of 19. Benefits under this endorsement terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the Policy terminates.

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network or out-of-Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

When Vision Care Services are obtained from an out-of-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described in this endorsement under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider, the Insured Person will be required to pay any Copayments at the time of service.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between the Company and the Vision Care Provider. The Company's negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

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

Policy Deductible

Benefits for pediatric Vision Care Services provided under this endorsement are not subject to any Policy Deductible stated in the Policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement does not apply to the Policy Deductible stated in the Policy Schedule of Benefits.

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.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

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.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

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.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company.

Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Schedule of Benefits

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|--|-----------------------------------|---------------------------------|---------------------------|
| Routine Vision Examination or Refraction only in lieu of a complete exam. | Once per year. | 100% after a Copayment of \$20. | 50% of the billed charge. |
| Eyeglass Lenses | Once per year. | | |
| • Single Vision | | 100% after a Copayment of \$40. | 50% of the billed charge. |
| • Bifocal | | 100% after a Copayment of \$40. | 50% of the billed charge. |
| • Trifocal | | 100% after a Copayment of \$40. | 50% of the billed charge. |

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|--|-----------------------------------|---------------------------------|----------------------------|
| <ul style="list-style-type: none"> Lenticular | | 100% after a Copayment of \$40. | 50% of the billed charge. |
| Lens Extras | Once per year. | | |
| <ul style="list-style-type: none"> Polycarbonate lenses | | 100% | 100% of the billed charge. |
| <ul style="list-style-type: none"> Standard scratch-resistant coating | | 100% | 100% of the billed charge. |
| Eyeglass Frames | Once per year. | | |
| <ul style="list-style-type: none"> Eyeglass frames with a retail cost up to \$130. | | 100% | 50% of the billed charge. |
| <ul style="list-style-type: none"> Eyeglass frames with a retail cost of \$130 - \$160. | | 100% after a Copayment of \$15. | 50% of the billed charge. |
| <ul style="list-style-type: none"> Eyeglass frames with a retail cost of \$160 - \$200. | | 100% after a Copayment of \$30. | 50% of the billed charge. |
| <ul style="list-style-type: none"> Eyeglass frames with a retail cost of \$200 - \$250. | | 100% after a Copayment of \$50. | 50% of the billed charge. |
| <ul style="list-style-type: none"> 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 | | | |
| <ul style="list-style-type: none"> Covered Contact Lens Selection | Limited to a 12 month supply. | 100% after a Copayment of \$40. | 50% of the billed charge. |
| <ul style="list-style-type: none"> 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:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number from the ID card.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

UnitedHealthcare Vision Network - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the Policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this endorsement in Section 1: Benefits for Pediatric Vision Care Services.

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.

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.uhcsr.com/myaccount 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.uhcsr.com/myaccount (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 Charge 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.

The Insured Person is not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a 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.

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Company at www.uhcsr.com/myaccount or by calling *Customer Service* at 1-855-828-7716.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular reference product.

Designated Pharmacies

If the Insured requires certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be paid based on the out-of-Network Benefit for that Prescription Drug Product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If the Insured requires Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Specialty Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and the Insured chooses not to obtain their Specialty Prescription Drug Product at a Designated Pharmacy, the Insured will be responsible for the entire cost of the Prescription Drug Product.

Please see the Definitions Section for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The following supply limits apply to Specialty Prescription Drug Products.

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.uhcsr.com/myaccount (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, (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), 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.uhcsr.com/myaccount (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.

Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others, therefore; a Prescription Drug may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information) or call Customer Service at 1-855-828-7716 for the most up-to-date tier placement.

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they applied to the Insured's Deductible or taken into account in determining the Insured's Copayments and/or Coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

Definitions

Brand-name means a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name 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 "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are a Designated Pharmacy.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - AHFS Drug Information (AHFS DI) under therapeutic uses section.

- Elsevier Gold Standard's Clinical Pharmacology under the indications section.
- DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb.
- National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings

Exceptions:

- Clinical trials for which benefits are specifically provided for in the Policy.
- The Company may, as it determines, 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 if:
 - The Insured is not a participant in a qualifying clinical trial as provided for in the Policy.
 - The Insured has a Sickness or Injury that is likely to cause death within one year of the request for treatment.
- Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, even though 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.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information) 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.

Out-of-Network Reimbursement Rate means the amount the Company will pay to reimburse an Insured for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

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.uhcsr.com/myaccount (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 (with spacers).
- 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;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose meters, including continuous glucose monitors.

Prescription Order or Refill means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Preventive Care Medications means the medications that are both:

- Obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician.
- Specified as a Preventive Care Medication in the Company's guidelines for preventive care services.

Company guidelines for preventive care services are based on the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Certain immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Care Medications are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible). No benefits will be provided for any Preventive Care Medications specifically excluded in the Policy.

The Insured may find out if a drug is a Preventive Care Medication at www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information) or by calling Customer Service at 1-855-828-7716.

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products at www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information) or call *Customer Service* at 1-855-828-7716.

Therapeutically Equivalent means when Prescription Drugs Products have essentially the same efficacy and adverse effect profile.

Unproven Service(s) means services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are determined not to be effective for the treatment of the medical or behavioral health condition or not determined to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.

- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

The Company has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Company issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. The Insured can view these policies at liveandworkwell.com.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, as it determines, consider an otherwise Unproven 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, even though unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

Usual and Customary Charge means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes a dispensing fee and any applicable sales tax.

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. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
5. 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.
6. 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.
7. 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.
8. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
9. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
10. Certain unit dose packaging or repackagers of Prescription Drug Products.
11. Medications used for cosmetic or convenience purposes.
12. 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.
13. 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.
14. 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.)
15. 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.
16. 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.
 17. 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.
 18. 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.
 19. 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.
 20. 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:
 - It is highly similar to a reference product (a biological Prescription Drug Product).
 - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.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 that was previously excluded under this provision.
 21. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
 22. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
 23. Diagnostic kits and products, including associated services.
 24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
 25. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
 26. A Prescription Drug Product that contains marijuana, including medical marijuana.

Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured’s representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-888-251-6253. The Company will notify the Insured Person of the Company’s determination within 72 hours.

Please note, if the request for an exception is approved, the Insured may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits.

Urgent Requests

If the Insured Person’s request requires immediate action and a delay could significantly increase the risk to the Insured Person’s health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-888-251-6253. The Independent Review Organization (IRO) will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-888-251-6253 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

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:

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

transportation and expenses associated with dispatching a medical practitioner to an Insured Person's location, not including the costs of the medical practitioner's service.

Medical Repatriation: After an Insured Person receives initial treatment and stabilization for a Sickness or Injury, if the attending physician and the *Medical Director* of the Company's affiliate or authorized vendor determine that it is medically necessary, the Company's affiliate or authorized vendor will transport an Insured Person back to the Insured Person's permanent place of residence for further medical treatment or to recover. 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 repatriation.

Transportation after Stabilization: If Medical Repatriation is not required following stabilization of the Insured Person's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation to the Insured Person's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match an Insured Person's originally booked travel arrangements) to the Insured Person's original point of origin, Home Country or Host Country.

Transportation to Join a Hospitalized Insured Person: If an Insured Person who is travelling alone is or will be hospitalized for more than three (3) days due to a Sickness or Injury, the Company's affiliate or authorized vendor will coordinate round-trip airfare for a person of the Insured Person's choice to join the Insured Person. The Company will pay costs for economy class round-trip airfare for a person to join the Insured Person.

Return of Minor Children: If an Insured Person's minor child(ren) age 18 or under are present but left unattended as a result of the Insured Person's Injury or Sickness, the Company's affiliate or authorized vendor will coordinate airfare to send them back to the Insured Person's Home Country. The Company's affiliate or authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by the Company's affiliate or authorized vendor. The Company will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Insured Person's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Insured Person's Home Country.

Repatriation of Mortal Remains: In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence.

CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to an Insured Person after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Insured Person or an authorized representative of the Insured Person of the need for the requested Assistance and Evacuation Benefits. In all cases, the requested Assistance and Evacuation Benefits services and payments must be arranged, authorized, verified and approved in advance by the Company's affiliate or authorized vendor.

With respect to any evacuation requested by an Insured Person, the Company's affiliate or authorized vendor reserves the right to determine, at its sole discretion, the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

In the event an Insured Person is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Insured Person.

The following Exclusions and Limitations apply to the Assistance and Evacuation Benefits.

In no event shall the Company be responsible for providing Assistance and Evacuation Benefits to an Insured Person in a situation arising from or in connection with any of the following:

1. Travel costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor.
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.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: The Company's affiliate or authorized vendor will assist the Insured Person in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: The Company's affiliate or authorized vendor will make new reservations for airlines, hotels, and other travel services for an Insured Person in the event of a Sickness or Injury, to the extent that the Insured Person is entitled to receive Assistance and Evacuation Benefits.

Transfer of Funds: The Company's affiliate or authorized vendor will provide the Insured Person with an emergency cash advance subject to the Company's affiliate or authorized vendor first securing funds from the Insured Person (via a credit card) or his/her family.

Legal Referrals: Should an Insured Person require legal assistance, the Company's affiliate or authorized vendor will direct the Insured Person to a duly licensed attorney in or around the area where the Insured Person is located.

Language Services: The Company's affiliate or authorized vendor will provide immediate interpretation assistance to an Insured Person in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, the Company's affiliate or authorized vendor will provide the Insured Person with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: Insured Persons may send and receive emergency messages toll-free, 24-hours a day, through the Company's affiliate or authorized vendor.

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/myaccount (or refer to your Summary Brochure for specific website for additional information) and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

- Caller's name, telephone and (if possible) fax number, and relationship to the Insured Person.
- Insured Person's name, age, sex, and ID Number as listed on the Insured Person's Medical ID card.
- Description of the Insured Person's condition.
- Name, location, and telephone number of hospital, if applicable.
- Name and telephone number of the attending physician.
- Information on where the physician can be immediately reached.

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

Attachment G

| | |
|---------------------------------|--|
| Bid Number: 50012-656-27 | Bid Title: Participant Coverage for Intercollegiate Athletics |
|---------------------------------|--|

The following pages include information related to the historical enrollment for International Students by country.

| Academic Year | 25-26 | 24-25 | 23-24 | 22-23 | 21-22 | 20-21 | 19-20 | 18-19 | 17-18 | 16-17 | 15-16 | 14-15 | 13-14 | 12-13 | 11-12 | 10-11 | 09-10 | 08-09 | 07-08 | 06-07 | 05-06 | 04-05 | 03-04 | 02-03 |
|----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Country | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students |
| Unknown | 1 | | 1 | | | | | | | | | | | | | | | | | | | | | |
| Afghanistan | | 1 | | | | | | | 2 | 5 | 4 | 4 | 2 | 1 | | | | | 1 | | | | | |
| Albania | | | | | | | | | | | | | | | | | 1 | 1 | 1 | 1 | | | | |
| Algeria | | | | | | | | | | | | | | | | | | | 1 | | 1 | | | |
| Angola | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 1 | 1 | | | | | | | | | | | | 1 | 1 | 1 | 1 |
| Antigua and Barbuda | | | | | | | | | | | | | | 1 | | | | | | | | | | |
| Argentina | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | | | | | | 3 | 4 | 4 | 3 | 2 | | | | | |
| Aruba | | | | | | | | | | | | | | | | | | | 1 | 2 | 3 | 3 | 3 | 2 |
| Australia | 2 | 2 | 2 | 3 | 3 | 1 | 1 | 2 | 1 | 1 | 1 | 3 | 2 | 1 | | | | | | | 1 | 1 | | |
| Austria | | | | | | | | | | | | | | | | | | | | | | 1 | | 1 |
| Azerbaijan | | | | | | | | | | | | | | | | 1 | 1 | 1 | 1 | | | | 1 | 2 |
| Bahamas | 2 | 2 | | 1 | 1 | 1 | | | | 2 | 4 | 4 | 5 | 4 | | | 1 | 2 | 2 | 1 | 4 | 5 | 5 | 5 |
| Bangladesh | 53 | 44 | 40 | 32 | 23 | 18 | 24 | 21 | 15 | 20 | 19 | 17 | 13 | 21 | 15 | 13 | 10 | 3 | 4 | 5 | 6 | 8 | 6 | 5 |
| Barbados | | | 1 | 1 | | | | 1 | | 1 | 1 | | | | | | | | | | | | | |
| Belgium | | | | | | 1 | 2 | 2 | 1 | | 1 | | | | | | | 1 | 1 | 1 | 1 | 2 | 1 | 1 |
| Benin | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | |
| Bermuda | | | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | | | | | | | |
| Bolivia | 1 | 3 | 2 | 5 | 6 | 7 | 10 | 7 | 8 | 8 | 11 | 13 | 8 | 7 | 5 | 4 | 3 | 3 | 2 | 2 | 1 | 2 | 2 | |
| Bosnia and Herzegovina | | | | | | | | | | | | | | | | | | 1 | | | | | | |
| Brazil | 2 | 4 | 4 | 3 | 7 | 5 | 4 | 1 | | 2 | 1 | 3 | 6 | 5 | 10 | 7 | 4 | 3 | 1 | 1 | 4 | 2 | 5 | 4 |
| Bulgaria | | | | | | 1 | 1 | | | | | | 1 | 2 | 3 | 2 | 1 | | | 1 | | | | |
| Burkina Faso | | | | | | | | | | | | | 1 | | | | | | | 1 | | | | |
| Burundi | | | | | | | | | | | | | 1 | 1 | 1 | 3 | 1 | | | | | | | |
| Cameroon | | | | 2 | 2 | 2 | 4 | 4 | 6 | 7 | 9 | 12 | 17 | 15 | 14 | 14 | 11 | 4 | 6 | 4 | 2 | 1 | | |
| Canada | 11 | 5 | 6 | 7 | 6 | 3 | 5 | 6 | 7 | 4 | 6 | 6 | 6 | 3 | 6 | 7 | 9 | 6 | 6 | 11 | 8 | 8 | 7 | 6 |
| Chad | | | | | | 1 | 1 | 1 | | | | | | | | | | | | | | | | |
| Chile | | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | | | | | |
| China | 9 | 10 | 10 | 12 | 18 | 31 | 43 | 54 | 75 | 87 | 96 | 93 | 99 | 91 | 91 | 78 | 66 | 49 | 45 | 58 | 71 | 103 | 130 | 139 |
| Colombia | 1 | 1 | 2 | 2 | 5 | 4 | 4 | 4 | 3 | | 1 | 1 | 1 | 1 | | | 1 | 2 | | 1 | | 1 | 2 | 1 |
| Comoros | | | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | | | | | | | |
| Cook Islands | | 1 | 1 | | | | | | | | | | | | | | | | | | | | | |
| Costa Rica | | | | | | | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Côte d'Ivoire | 2 | 3 | 5 | 9 | 11 | 15 | 14 | 10 | 3 | 1 | 1 | 1 | | 2 | 2 | 2 | 1 | | | | | | | |
| Croatia | | | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | | | | 1 | | | |
| Cyprus | | | | | | | | | | | | | | | | | | 1 | 1 | 1 | 2 | 3 | 1 | 2 |
| Czech Republic | | | | | | | | | | | | | | | | | | | | | | | | 1 |
| Democratic Republic of the Congo | 1 | | 2 | 1 | | | | | | | | | | | | | | | | | | | | |
| Denmark | | 1 | 1 | | | | | | | | | | | | | | | | | | 1 | | | |
| Dominica | 3 | 1 | 2 | 1 | 1 | 1 | 2 | 3 | 3 | 1 | 1 | | | 2 | 3 | 2 | | | | | | | | |
| Dominican Republic | 1 | | | | | | | | | | | | | | | | | | | | | | | 1 |
| Ecuador | | | | | | | | | | | 1 | 1 | 2 | 1 | 1 | 1 | | | 1 | 3 | 3 | 2 | 1 | 2 |
| Egypt | 3 | 3 | 2 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | | | | | | | | 1 | 1 | 1 | | 2 | 1 |
| El Salvador | 3 | 3 | 3 | 4 | 5 | 4 | 3 | 2 | 2 | 3 | 2 | 3 | 4 | 2 | 2 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | 1 |
| Equatorial Guinea | | | | | | | | | | | | | 2 | 2 | | | | | | | | | | |
| Ethiopia | | | | | | | | 1 | 2 | 2 | 2 | | 1 | 3 | 4 | 5 | 5 | 3 | 4 | 3 | 3 | 3 | 2 | 1 |
| Finland | 1 | 2 | 1 | | | | | | | 1 | 1 | 1 | | | | | | | | | 1 | | | |

| Academic Year | 25-26 | 24-25 | 23-24 | 22-23 | 21-22 | 20-21 | 19-20 | 18-19 | 17-18 | 16-17 | 15-16 | 14-15 | 13-14 | 12-13 | 11-12 | 10-11 | 09-10 | 08-09 | 07-08 | 06-07 | 05-06 | 04-05 | 03-04 | 02-03 |
|----------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Country | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students | Students |
| United Kingdom | 4 | 6 | 1 | 1 | 2 | 3 | 3 | 3 | 3 | 5 | 4 | 4 | 5 | 5 | 5 | 3 | 3 | 1 | | 1 | 2 | 1 | 3 | 1 |
| United States | 7 | | 1 | 1 | 1 | 1 | | | | | | 1 | 1 | 2 | 2 | 2 | | | | | | | | 1 |
| Uruguay | | | | | | | | | | | | | | | | | | 1 | 1 | 1 | 1 | | | |
| Venezuela | | | | | 1 | 3 | 1 | 1 | 4 | 4 | 3 | 2 | 1 | 1 | | 2 | 3 | 4 | 5 | 5 | 6 | 4 | 5 | 4 |
| Vietnam | 3 | 3 | | | 4 | 7 | 10 | 10 | 10 | 9 | 9 | 9 | 8 | 11 | 9 | 8 | 5 | 3 | 2 | 4 | 4 | 6 | 4 | 2 |
| Virgin Islands | | | | | | | | | | | | | | | | | | | | | 1 | | | 2 |
| Yemen | | | | | | | | | | 1 | 1 | 2 | 1 | | | | | | | | 1 | 1 | 1 | 1 |
| Zambia | 1 | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 2 |
| Zimbabwe | | 1 | | | | | | | | | | | | | 1 | 1 | 1 | 1 | | | 1 | 1 | | 1 |
| Total | 497 | 542 | 344 | 295 | 280 | 312 | 388 | 387 | 396 | 409 | 469 | 567 | 631 | 665 | 647 | 660 | 598 | 534 | 510 | 508 | 646 | 728 | 715 | 529 |