INTRODUCTION

Clarke University is vitally concerned with the health and well being of its students. This Student Accident and Health Plan is designed to provide low cost coverage for unanticipated medical expenses. The plan described in this brochure is made available as a service to Our students. The Policy will coordinate with any other valid and collectible insurance or plan.

ELIGIBILITY

Students are expected to participate in the Student Accident and Health Plan offered through the university unless similar coverage is being carried by the student or parent. All full time registered students enrolled for a minimum of 12 credit hours or more, and part-time students taking 6 credit hours or more, attending Clarke University are eligible to participate in this program.

REFUND PROVISION

In the event an Insured person leaves school to enter active military service, coverage will cease and a pro rata refund of premium will be made upon request. Other than as stated here, no refunds are available.

TERM OF COVERAGE

The policy for the current year becomes effective on August 15, 2011 at 12:01 a.m.; or the date the proper premium is received by the Servicing Agent. All coverage terminates on the earliest of: a) when payment is due and unpaid; or the date the covered person enter the armed forces; or when the policy terminates on August 15, 2012 at 12:01 a.m. Coverage remains in effect during holiday and vacation periods. Should an Insured person graduate or withdraw from the institution, the insurance shall remain in effect until the end of the period for which premium has been paid.

Enrollment is only allowed during the open enrollment period which is August 15, 2011 to September 30, 2011 for the Fall session or January 1, 2012 to February 17, 2012 for the Spring enrollment. Exceptions will be made for the following:

1. Adding a new spouse or dependent child (within 31 days of marriage, birth, or adoption).
2. Enrolling as a new or transfer student within 31 days of enrollment at the school.
3. Within 31 days of ineligibility under another plan of Credible Coverage and accepted and exhausted COBRA continuation of coverage if offered.

PREMIUM RATES

	Annual	Fall	Spring/Summer
Student	$800	$333	$466
Spouse	$2,850	$1,188	$1,663
Each Child	$665	$277	$388

3. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

(A.) Certain facts are needed to apply these COB rules. The insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person.

(B.) The insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the insurer any facts it needs to pay the claim.

(VI) FACILITY OF PAYMENT

(A) A payment made under another plan may include an amount, which should have been paid under this plan. If it does, the insurer may pay that amount to the organization, which made that payment. That amount will then be treated, as though it were a benefit under this plan.

(B) The insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY

(A) If the amount of the payment made by the insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of:
1) the persons it has paid or for whom it has paid;
2) insurance companies;
3) other organizations.

(B) The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Conformity with State Statutes

Any provision of this plan of insurance which, on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

Any Expense not specifically listed in the preceding sections is not covered.

Underwritten by:

MARKEL INSURANCE COMPANY

Glen Allen, VA 23060

First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501
Phone: (269) 381-6630
Fax: (269) 381-3055

Local Agent:
O'Connor & Associates Insurance Agency, Inc.
P.O. Box 737
Dubuque, IA 52001

Mail claims to:

MCA Administrators, Inc.
A Markel Business Partner
P.O. Box 6540
Harrisburg, PA 17112
1-800-427-9308
Fax: 1-717-652-8328
Student-insurance@mcoa.com

This outline of coverage is intended only for quick reference and does not limit or amplify the coverage as described in the master policy which contains complete terms and provisions.
A copy of the master policy is on file at the institution.

Blanket Accident and Health Plan

Designed for the Students of:

Clarke UNIVERSITY

1550 Clarke Drive
Dubuque, IA 52001

2011-2012

Policy Number: 11200710

Please keep this outline of coverage for future reference

2011 - 2012 Clarke University Student Insurance Application

STUDENT INFORMATION

Student's Name: _____ Student ID#: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Local Address: _____ City: _____ State: _____ Zip: _____

Student Signature _____ Date _____

Check (✓) the plan you have selected. For DEPENDENT COVERAGE, complete application and information requested on bottom of form.

CHOOSE PLAN

ANNUAL ACCIDENT AND HEALTH PLAN 8-15-2011 TO 8-15-2012

- ❑ Student $800.00
- ❑ Spouse $2,850.00
- ❑ Each Child $665.00

FALL ACCIDENT AND HEALTH PLAN 8-15-2011 TO 1-1-2012

- ❑ Student $333.00
- ❑ Spouse $1,188.00
- ❑ Each Child $277.00

SECOND SEMESTER AND SUMMER ACCIDENT AND HEALTH PLAN 1-1-2012 TO 8-15-2012

- ❑ Student $466.00
- ❑ Spouse $1,663.00
- ❑ Each Child $388.00

OPTIONAL CATASTROPHIC PAID AT 80% TO $100,000 $15,000 DEDUCTIBLE $100,000 MEDICAL MAXIMUM

❑ x _____ at $298.00 per person

DEPENDENT INFO

Spouse Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Child's Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Child's Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

disease); premarital examinations; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; smoking cessation; tubal ligation; vasectomy; and weight reduction. ;

- Injury resulting from the practice or play of intercollegiate and club sports in excess of $500; or
- Pre-Existing Conditions.

CLAIM PROCEDURE

To file a claim under the Accident and Health Plan, the student should:

1. Complete a claim form, if applicable, and submit it to the Claims Administrator. Claim forms must be completed and signed for accident claims. A claim form is not required for sickness claims, although in certain circumstances one may be requested by the Claims Administrator for completion. Claim forms are available from the Claims Administrator or from First Agency, the Servicing agent.
2. Submit itemized medical and Hospital bills within 90 days from the date of loss to the Claim Administrator. Please indicate in your submission, the student,'s school name, student name, policy number and student Social Security number even if the charges are for a spouse or dependent.
3. Preauthorization and precertification of benefits to providers of medical service are not required nor provided by Us.
4. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator.

Markel Privacy Practices

We maintain physical, electronic and procedural safeguards that comply with federal standards to protect Your personal information. We do not use or disclose Your information for any fundraising, marketing or research activities.

We use and disclose Your information to determine Your eligibility for plan benefits, to facilitate payment for treatment and services provided to You, to coordinate benefits and to carry out other necessary insurance-related activities. We use or disclose the minimum information necessary to process a claim or answer a claims inquiry. We may also disclose Your information to law or government agencies when required by law to do so.

Under the privacy laws, You have unlimited access to Your information. You may limit how We use and disclose Your information and get a listing of instances where it was disclosed. You may request that We correct inaccurate information or add missing information.

If You have any questions about Your rights, Our Privacy Practices or You want to file a complaint, please contact Our Privacy Officer at: **Phone (800) 431-1270 or www.MarkelAH.com.**

EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

- Expenses for dental treatment, except for treatment resulting from Injury to natural teeth; or except as provided in the Dental Expense Benefit; or as specifically provided by a Sickness Dental Expense Benefit, if included in the policy;
- Services normally provided without charge by the Policyholder,'s health service, infirmary, Hospital or employees;
- Routine eye exams and contacts, replacing eyeglasses or prescription therefor; routine examinations and services related to hearing examinations or hearing aids; or treatment for hearing defects not related to an Injury or Sickness;
- Routine physical examinations; preventive care; elective surgery and elective treatment; services solely to improve appearance; for personal hygiene; services specifically for dietary control; custodial, sanitarial or rest care; or fertility testing;
- Cosmetic surgery. Cosmetic surgery does not include reconstructive surgery which results from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or deformity of a dependent child. Cosmetic surgery due to congenital defects will be covered for newborn children;
- False labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy;
- Treatment or supplies for the newborn infant except that required for the treatment of a covered Accident or Sickness;
- Voluntary termination of pregnancy;
- Skydiving; recreational parachuting; hang gliding; glider flying; parasailing; sail planing; bungee jumping; or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
- Injury or Sickness resulting from any declared or undeclared war;
- Injury due to participation in a riot; commission of or attempt to commit a felony;
- Suicide, attempted suicide or intentionally self-inflicted Injury;
- Injury or Sickness while in the armed forces of any country. When an Insured enters such armed forces, We will refund the unearned pro rata premium to the Insured;
- Injury or Sickness covered by any workers', compensation or occupational disease law;
- Injury or Sickness resulting from being under the influence of alcohol or drugs unless taken on a Physician,'s advice;
- Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
- Surgery and/or treatment for acne; acupuncture; allergy, including allergy testing; biofeedback-type services; breast implants or breast reduction; circumcision; corns, calluses and bunions; deviated nasal septum, including submucuous resection and/or other surgical correction thereof, unless due to Injury occurring while coverage is in force; family planning; fertility tests; hair growth or removal; impotence, (organic or otherwise); learning disabilities; nonmalignant warts, moles, and lesions; obesity and any condition resulting therefrom, (including hernia or any kind, diabetes or heart

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hours after delivery by an uncomplicated cesarean section. Any decision to shorten the length of stay listed above shall be made by the attending Physician, after conferring with the mother. If the mother and newborn are discharged early, coverage shall be provided for a follow up visit, provided by providers competent in postpartum care and newborn assessment.

Reconstructive Breast Surgery Expense: We will pay the Expense incurred in connection with reconstructive breast surgery after a mastectomy as follows: a) all stages of reconstruction of the breast on which the mastectomy has been performed; b) surgery and reconstruction on the other breast to produce a symmetrical appearance; and c) prostheses and physical complications of mastectomy, including lymphedemas.

Diabetes Expense: We will pay the Expense incurred in connection with the treatment of diabetes as follows: a) equipment; b) supplies; and c) self management training and education. Self management training and education shall be paid only under both of the following conditions: a) the Physician certifies such services are needed under a comprehensive plan of care related to the diabetic condition to ensure therapy compliance or to provide the Insured with necessary skills and knowledge to participate in the management of their condition; and b) the program is certified by the Iowa Department of Public Health.

Well Child Care Expense: We will pay the Expense incurred in connection with well child care services. "Well child care," means pediatric preventive services appropriate to the age of a child from birth to age seven as defined by current Recommendations for Preventive Pediatric Health Care of The American Academy of Pediatrics. Preventive services shall include: a) history and complete physical examination; b) developmental assessment; c) anticipatory guidance; d) immunizations; e) vision and hearing screening; and f) laboratory services including, but not limited to screening for lead exposure as well as blood levels.

TRAVEL BENEFITS

All services or benefits provided in this policy and outlined below must be pre-approved by Us or Our representative. Travel Benefits are provided by AXA Assistance USA. To access service please call: 1-888-735-8473

Emergency Evacuation Benefit

We will pay for Covered Emergency Evacuation Expenses incurred if the Insured person suffers an Injury or Sickness that requires Emergency Evacuation while on Covered Travel. Benefits payable are subject to a maximum amount per Insured person of $10,000 for all Emergency Evacuations due to all Injuries from the same Accident or all Sicknesses from the same or related causes, and this is also the aggregate maximum for all travel benefits including Medically Necessary Transportation and the Repatriation of Remains Benefit.

The Physician must order the Emergency Evacuation and must certify that the severity of the Insured person's Injury or emergency Sickness warrants his or her Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

Medically Necessary Transportation

If the Insured person is hospitalized for more than five consecutive days following a Covered Emergency Evacuation, We will pay, subject to any limitations stated herein, for Expenses to return the Insured person from the medical facility to which he or she was treated to the Insured person's return destination, less refunds from the Insured person's unused Transportation tickets. Airfare costs will be economy or first class if the Insured person,'s original tickets are first class.

Repatriation of Remains Benefit

If the Insured person suffers a covered loss of life while on Covered Travel, We will pay, subject to the limitations stated below, for Covered Expenses reasonably incurred to return the Insured person's body to their home country, but not exceeding a maximum per Insured person benefit amount of $10,000, and this is also the aggregate maximum for all travel benefits including the Emergency Evacuation Benefit and Medically Necessary Transportation.

Covered Expenses. Covered Expenses include, but are not limited to, Expenses incurred in accordance with the applicable international requirements for:

(1) embalming;
(2) cremation;
(3) the most economical coffins or receptacles adequate for Transportation of the remains; and
(4) Transportation, according to airline tariffs, of the remains by the most direct and economical conveyance and route possible.

Benefits will not be provided for any Expense provided by another party at no cost to the Insured person or already included in the cost of the Covered Travel.

We or Our representative must authorize all Expenses in advance for any travel benefit to be payable.

DEFINITIONS

The following definitions apply to the aforementioned Travel Benefits:

Covered Travel means any travel 100 miles or more from home.

Covered Emergency Evacuation Expenses are those for Medically Necessary Transportation, including Usual and Customary medical services and supplies incurred in connection with the Emergency Evacuation of the Insured person. Expenses for Transportation must be: (1) recommended by the attending Physician; and (2) required by the standard regulations of the conveyance transporting the Insured person.

Emergency Evacuation means: (1) the Insured person's medical condition warrants immediate Transportation from the place where the Insured person is injured or sick to the nearest Hospital where appropriate medical treatment can be obtained; (2) after being treated at a local Hospital, the Insured person's medical condition warrants Transportation to the United States or Canada (where he or she resides) to obtain further medical treatment or to recover; or (3) both (1) and (2) above.

(3) Dependent child / separated, divorced parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a) first, the plan of the parent with custody of the child;
   b) then, the plan of the spouse of the parent with the custody of the child; and
   c) finally, the plan of the parent not having custody of the child.
(4) If the specific terms of a court decree state that one of the parents is responsible for the health care Expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
(5) Active / inactive employee. The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan, which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.
(6) Longer / shorter length of coverage. If none of the above rules determine the order of benefits, the benefits of the plan, which covered an employee, member or subscriber longer is determined before those of the plan, which covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

A) When this section applies. This section IV applies when, in accordance with Section III, Order of Benefit Determination Rules, this plan is secondary as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plan" in (B) immediately below.

(B) Reduction in this plan's benefits. The benefits of this plan will be reduced when the sum of:
   1. The benefits that would be payable for the allowable Expenses under this plan in the absence of this COB provision; and
   2. The benefits that would be payable for the allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceed those allowable Expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable Expenses.

STUDENT HEALTH SERVICES (SHS) REFERRAL

The student must use the resources of the Student Health Services first where treatment will be administered or a referral issued. Expenses incurred for medical treatment rendered outside the Student Health Services for which no prior approval or referral is obtained will be excluded from coverage. Student Health Services personnel must initial the claim form to verify referral. A SHS referral from outside care is not necessary, only under the following conditions: 1) Medical Emergency; 2) When the Student Health Services is closed; 3) When service is rendered at another facility during break and vacation periods; 4) Medical care received when the student is more than 25 miles from campus; 5) Medical care obtained when a student is no longer able to use the SHS due to change in student status. Dependents are not eligible to use the SHS, and therefore, are exempt from the above limitations and requirements.

DEFINITIONS

Accident means a sudden, unexpected and unintended event which is identifiable and caused solely by an external physical force resulting in Injury to an Insured person. Accident does not include a Loss due to or contributed to by disease or Sickness.

Deductible means the amount an Insured is required to pay as provided by the applicable coverage under the policy in the event of a Loss.

Expense means the Usual and Customary charges for Medically Necessary treatment, service or supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

Hospital means a licensed institution including a tax-supported institution of the state which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Physician. It must have a Registered Nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a Hospital, unless such confinement is because of a lack of space in the Hospital's full service wing.

Injury means bodily harm caused by an Accident which occurs while the policy is in force and is the sole cause of the Loss.

Insured means an eligible student or an eligible student's dependent (if dependent coverage is available under the policy).

Loss means medical Expense caused by Injury or Sickness and covered by the policy.

Medically Necessary means medical services, supplies or treatment authorized by a Physician to treat an Insured person's bodily Injury or Sickness which are: (a) consistent with the symptoms or diagnosis; (b) appropriate and accepted according to good medical practice standards; (c) not primarily for the convenience of the Insured person, Physician or other providers; and (d) consistent with the most appropriate supply or level of services which can safely be provided to the patient.

Physician means any practitioner of the healing arts, licensed by the state in which he practices and acting within the scope of his license, including a duly licensed podiatrist, surgeon, osteopath, dentist, chiropractor, optometrist, psychologist, physical therapist, and graduate nurse. Physician shall not include a member of the Insured's immediate family.

Pre-Existing Condition means any condition for which medical advice or treatment was received or recommended within the six months immediately preceding Your effective date of coverage. This exclusion applies for 12 months after Your effective date of coverage. This exclusion does not apply to a pregnancy existing on Your effective date of coverage. We shall credit the time You were previously covered under a previous health insurance plan or policy or employer provided health benefit arrangement, if the previous coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Such credit shall apply to the extent that the previous coverage was substantially similar to the new coverage. The creditable coverage outlined above means any prior health care coverage as defined in HIPAA which includes group coverage; individual coverage; Medicare; Medicaid; military service related care; Indian health service or tribal organization coverage; state health benefits risk pool; a public program offered under the Federal Employees Health Benefits Program; a public health plan; Peace Corps Act health plan; state children's health programs (S-CHIP); and foreign national health plans.

Sickness means disease or illness which causes a Loss while the Insured is covered by the policy. Sickness includes normal pregnancy and complications of pregnancy.

Usual and Customary Expense means an Expense which: (a) is charged for treatment, supplies or medical services Medically Necessary to treat the Insured's condition; and (b) does not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where the Expense is incurred.

We, Us or Our means Markel Insurance Company.

You, Your or Yours means the Insured.

DESCRIPTION OF BENEFITS

SECTION I
BASIC ACCIDENT BENEFITS

When Your Injury requires: (a) treatment by a Physician; (b) Hospital confinement; (c) services of a licensed practical nurse or R.N.; (d) x-ray service; (e) use of an operating room, anesthesia, including the administration thereof, laboratory service; (f) use of an ambulance; (g) use of an ambulatory surgical center or ambulatory medical center; (h) if ordered by a Physician, prescription medicines, drugs or any other therapeutic services or supplies; or (i) home health care Expenses, We will pay the Expense incurred within 52 weeks after the date of the Accident up to an aggregate maximum of $2,500. This benefit includes coverage for treatment of Injury to natural teeth.

Intercollegiate and Club sports Injuries are limited to a medical maximum of $500 per Injury.

(D.) "Allowable Expense" means a necessary, reasonable, and customary item of Expense of health care, when the item of Expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, as specifically defined in the plan, or in the event the Hospital lacks an acceptable semiprivate room for the patient. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable Expense and a benefit paid.

(E.) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date of this COB provision or a similar provision takes effect.

(III) ORDER OF BENEFIT DETERMINATION RULES

(A.) General. When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of this plan; and
2. Both those rules and this plan's rules, in subparagraph B below, require that this plan's benefits be determined before those of the other plan.

(B) Rules. This plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent child / parents not separated or divorced. Except as stated in subparagraph (B) (3) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents".

a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

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

c) If the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Transportation means any land, sea or air conveyance required to transport the Insured person during an Emergency Evacuation. Transportation includes, but is not limited to, air ambulance, land ambulance and private motor vehicles.

COORDINATION OF BENEFITS

(I) APPLICABILITY

(A.) This Coordination of Benefits (COB) provision applies to this plan when an Insured or an Insured's covered dependent has health care coverage under more than one plan.

(B.) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan.

The benefits of this plan:

1. shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
2. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section (IV), effect on the benefits of this plan.

(II) DEFINITIONS

(A.) "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, or the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any contract or other nongovernmental program. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate plan.

(B.) "This Plan" is the part of the group contract that provides benefits for health care Expenses.

(C.) "Primary Plan"/ "Secondary Plan" The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

SECTION II
BASIC SICKNESS BENEFITS

When Your Sickness requires: (a) treatment by a Physician; (b) Hospital confinement; (c) services of a licensed practical nurse or R.N.; (d) x-ray service; (e) use of an operating room, anesthesia, including the administration thereof, laboratory service; (f) use of an ambulance; (g) use of an ambulatory surgical center or ambulatory medical center; (h) if ordered by a Physician, prescription medicines, including hormone replacement therapy that if prescribed or ordered for treating symptoms and conditions of menopause, drugs or any other therapeutic services or supplies; or (i) home health care Expenses, We will pay the Expense incurred within 52 weeks after the date of first medical treatment for the Sickness up to an aggregate maximum of $2,500.

SECTION III
SUPPLEMENTAL EXPENSE BENEFIT

If the covered medical Expense for Your Injury or Sickness exceeds the aggregate maximum We pay under the basic Accident or basic Sickness benefits, We will pay 80% of the Expense up to a maximum of $12,500. Covered Expenses for daily Hospital room and board will not be more than the usual semi-private room charge.

OPTIONAL CATASTROPHIC ACCIDENT AND SICKNESS COVERAGE

The combined medical maximum for the Basic Accident /Basic Sickness and the Supplemental Expense Benefit is $15,000. Coverage is available to a medical Maximum of $100,000 on an optional basis for an additional premium. Benefits are paid, after payment of the $15,000 deductible, at 80% to $100,000 for students and dependents.

The annual premium for this coverage is $298 per person. See the enrollment card to enroll.

MANDATED BENEFITS

The following benefits are mandated by state regulation. These benefits are provided: 1) to the extent that the type of Expense is covered under the basic policy; and 2) at the same payment level as any other Sickness or Injury, unless otherwise stated below.

Mammography Expense: We will pay the Expense for mammography screening for breast cancer screening or diagnosis, or for any non-symptomatic woman covered under the policy subject to the following: a) one baseline mammogram for any woman who is 35 through 39 years of age, or more frequent mammograms if recommended by the woman's Physician; b) a mammogram every two years for any woman who is 40 through 49 years of age, or more frequently if recommended by the woman's Physician; c) a mammogram every year for any woman who is 50 years of age or older, or more frequently if recommended by the woman's Physician.

Maternity Care Expense: We will pay the Expense incurred in connection with maternity care as follows: a) inpatient hospitalization services for a covered mother and a newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery; and b) 96