INTERNATIONAL ACCIDENT OR SICKNESS MEDICAL BENEFIT PLAN
CERTIFICATE OF COVERAGE

POLICYHOLDER:	SMIC Trust
PARTICPATING MEMBER	Drake University (15-5288-24) 2507 University Avenue Des Moines, IA 50311
EFFECTIVE DATE:	July 31, 2024
EXPIRATION DATE:	July 30, 2025

This Certificate describes the terms and conditions of benefits under the Policy issued by Pan American International Insurance Corporation (A Stock Company) (herein referenced as "the Company").

The Company agrees to provide benefits, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy.

Coverage under this Certificate becomes effective at 12:00 A.M. at the address of the Participating Member on the Effective Date shown above if the premium is paid according to the agreed terms. This Certificate terminates at 11:59 PM, on the Expiration Date shown above.

Patient Protection and Affordable Care Act ("PPACA") Disclosure Statement

These benefits are not subject to, and do not provide some of the benefits required by, the United States PPACA. In no event will We provide benefits in excess of those specified in the Policy, and these benefits are not subject to guaranteed issuance or renewal.

THIS IS LIMITED BENEFIT COVERAGE. READ IT CAREFULLY.
THIS POLICY IS NOT RENEWABLE.

PAN-AMERICAN INTERNATIONAL INSURANCE CORPORATION

Bruce G. Parker Jr.
President and Chief Executive Officer

NON-PARTICIPATING

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SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Certificate provisions carefully.

The Schedule of Benefits provides a brief outline of the coverage and benefits provided by this Certificate. Please read each Benefit Description section for full details.

ELIGIBLE PERSONS: An Eligible Person is an individual who meets all of the requirements of the Covered Classes shown below:

Class 1. An international student or other person with a valid F, J or M visa status, temporarily located outside His Home Country as a non-resident alien and:

a. Is engaged in educational or cultural activities of the Participating Member; and
b. Has not obtained permanent residency status in the United States; and
c. Is not a U.S. Citizen.

Class 2**.** Eligible Dependents of any of the above classes

If, subject to all the terms and conditions of this Certificate, a Covered Person is eligible for insurance under multiple Classes described above, then such Covered Person will only be insured under the Class which provides the Covered Person the largest benefit amount for the Covered Loss that has occurred.

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Any benefit limits and Benefit Percentages, Coinsurance, Copayments for *Accident & Sickness Medical Expense Benefits* apply, unless otherwise specified, on a per Covered Person basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable. Any Coinsurance, Copayments, Deductibles, Benefit Periods, Out-of-Pocket Maximums, Benefit Limits and Benefit Maximums apply on a per Covered Person basis.

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT OR SICKNESS MEDICAL EXPENSE BENEFITS Coordination of Benefits

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFIT

Total Maximum per Accident or Sickness

Medical and Other Expense Benefits Per Policy Year	$1,000,000
First Covered Expenses must be Incurred within	30 days after the covered Accident or Sickness
Coinsurance	In-Network Provider: 90% of the Negotiated Rate Out-of-Network Provider: 70% of U&C
Out-of-Pocket Maximum per Policy Year	$3,000
Benefit Period	per Policy Year
Deductible per Policy Year per Individual	$100

Covered Expenses for which benefits are payable are outlined below. Unless otherwise indicated, benefits are payable as a percentage of Usual and Customary Charges.

Payment of Covered Expenses for In-Network Providers is based on the Insurer's Negotiated Rate. In-Network Providers have agreed to accept the Negotiated Rate as payment in full.

All Deductibles for an Injury or Sickness are waived if treatment is received at the Recognized Student Health Center.

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Covered Expenses	**In-Network Provider**	**Out of Network Provider**
In-Patient Hospital Services		
Room and Board Expenses	90% of the Negotiated Rate subject to a $50 Copay per visit	70% of U&C at the semi-private room rate subject to a $100 Copay per visit
Intensive Care Unit or Coronary Care Unit Expenses	90% of the Negotiated Rate subject to a $50 Copay per visit	70% of U&C subject to a $100 Copay per visit
Hospital Miscellaneous Expenses	90% of the Negotiated Rate subject to a $50 Copay per visit	70% of U&C subject to a $100 Copay per visit
Emergency Room and Emergency Room Treatment	90% of the Negotiated Rate subject to a $100 Copay per visit. Copay waived if admitted	70% of U&C subject to $100 Copay per visit. Copay waived if admitted
Out-Patient Hospital Miscellaneous Expenses	90% of the Negotiated Rate subject to a $50 Copay per visit	70% of U&C subject to a $100 Copay per visit
Physician Services		
Surgery	90% of the Negotiated Rate	70% of U&C
Assistant Surgeon	90% of the Negotiated Rate	70% of U&C
Second Opinion or Consultation	90% of the Negotiated Rate subject to a $15 Copay per visit	70% of U&C subject to a $25 Copay per visit
Anesthesia and its Administration	90% of the Negotiated Rate	70% of U&C
In-Hospital Visits	90% of the Negotiated Rate	70% of U&C
Out-Patient Office Visits	90% of the Negotiated Rate subject to a $15 Copay per visit	70% of U&C subject to a $25 Copay per visit

Pre-Admission Testing	90% of the Negotiated Rate	70% of U&C
Out-Patient X-Rays	90% of the Negotiated Rate	70% of U&C
Out-Patient Laboratory Tests	90% of the Negotiated Rate	70% of U&C
Out-Patient Physical Therapy	90% of the Negotiated Rate	70% of U&C
In-Patient Physical Therapy	90% of the Negotiated Rate	70% of U&C
Ambulance Services	90% of the Negotiated Rate	70% of Actual Charges
Radiation/Chemotherapy Benefit	90% of the Negotiated Rate	70% of U&C
Dental Services Maximum Benefit is $500 per Policy Year.	90% of the Negotiated Rate	70% of U&C
Prescription Drugs Based on a 30-day supply per prescription.	100% of Actual Charges; subject to a $10 Copay per prescription for generic drugs 100% of Actual Charges; subject to a $30 Copay per prescription for brand drugs 100% of Actual Charges; subject to a $50 Copay per prescription for specialty drugs	70% of Actual Charges
Contraceptive Drugs & Devices Based on a 30-day supply per prescription.	100% of Actual Charges	100% of Actual Charges
Amateur, Intercollegiate, Club and Interscholastic Athletic Sports Conditions $10,000 maximum per Policy Year	90% of the Negotiated Rate	70% of U&C
Behavioral Health Services Expense Benefit **Mental and Nervous Disorders**		
In-Patient Expenses	90% of the Negotiated Rate subject to a $50 Copay per admission	70% of U&C subject to a $100 Copay per admission
Out-Patient Expenses	90% of the Negotiated Rate subject to a $15 Copay per visit	70% of U&C subject to a $25 Copay per visit
Wellness Expense Benefit Maximum Benefit is $1,000 per Policy Year Not subject to Copays or the plan Deductible	90% of the Negotiated Rate	70% of U&C

Pregnancy, Complications of Pregnancy, Maternity and Pre-Natal Expense Benefit Conception must occur while continuously covered under the Participating Member's plan	90% of the Negotiated Rate	70% of U&C
Behavioral Health Services Expense Benefit **Substance Abuse; Alcohol & Drug Abuse**		
In-Patient Expenses	90% of the Negotiated Rate subject to a $50 Copay per admission	70% of U&C subject to a $100 Copay per admission
Out-Patient Expenses	90% of the Negotiated Rate subject to a $15 Copay per visit	70% of U&C subject to a $25 Copay per visit
Urgent Care Facility	90% of the Negotiated Rate subject to a $15 Copay per visit	70% of U&C subject to $25 Copay per visit
Pre-Existing Conditions during the first 3 months of continuous coverage Maximum Benefit is $2,500 per Policy Year	90% of the Negotiated Rate	70% of U&C
Pre-Existing Conditions after 3 months of continuous coverage	90% of the Negotiated Rate	70% of U&C
Rehabilitative Braces and Appliances	90% of the Negotiated Rate	70% of U&C
HIV infection, HIV related illness and AIDS Lifetime Maximum Benefit is $7,500	90% of the Negotiated Rate	70% of U&C
Extension of Benefits (during Hospital Confinement upon policy cancellation)	90% of the Negotiated Rate	70% of U&C
Pediatric Dental **Basic Services** **(includes preventive and diagnostic)** **Intermediate Services** **(includes minor restorative services)** **Major Services** **(includes major restorative, endodontic and prosthodontic services)** **Orthodontics** **General Services** **(includes anesthesia services, intravenous sedation, consultations, medicals, and post-surgical services)**	 90% of U&C 55% of U&C 35% of U&C 50% of U&C 70% of U&C	
Pediatric Vision	90% of U&C up to $150 maximum	

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. Key terms used in this Policy are defined below. They are capitalized wherever they appear in this Policy.

Accident means a sudden, unforeseeable event that results, directly and independently of all other causes, in a covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, or mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

AIDS means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Age means the Covered Person's age, for purposes of initial premium calculations, attained on the later of the first day of the Policy Term and the date coverage becomes effective for Him under this Policy.

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Ambulatory Medical or Surgical Center means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. is primarily engaged in performing surgery on its premises;
3. has a licensed medical staff, including Physicians and Registered Nurses;
4. has permanent operating room(s), recovery room(s) and equipment for Emergency medical care; and
5. has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the Ambulatory Surgical Facility.
6. does not require Hospital Confinement.

Benefit Percentage means the percentage of Covered Expenses We pay that are incurred by the Covered Person after He satisfies any applicable Deductible. Benefit Percentages are shown in the Schedule of Benefits.

Benefit Period means the period of time from the date of the Sickness or Injury for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Child(ren) means an Eligible Person who has not reached the Age of 26 years of Age or older. Children includes a legally adopted child, foster child or stepchild that must be placed with the Covered Person while covered under this Policy.

Coinsurance means the ratio by which the Covered Person and the Company share in the payment of Covered Expenses for Medically Necessary treatment after the Deductible, if any, has been met. The percentage the Company pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Complications of Pregnancy means conditions, when the Pregnancy is not terminated, whose diagnoses are distinct from the Pregnancy, but are adversely affected by the Pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompression, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include termination of ectopic pregnancy, and spontaneous termination of Pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include elective abortion, elective cesarean section, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of Pregnancy, hyperemesis gravidarum, and similar conditions associated with the management of a difficult Pregnancy not constituting a distinct complication of Pregnancy. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous Pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Confinement or Confined means the continuous period a Covered Person spends as an In-Patient in a Hospital due to the same or related cause.

Copayment or Copay means a specified charge that the Covered Person is required to pay when a medical service is rendered.

Cosmetic Surgery means surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

Country of Assignment means where the Covered Person has a valid visa, if required, and in which He is undertaking an educational activity.

Covered Expenses means the Usual and Customary Charges or the Negotiated Rate for In-Network Providers for services or supplies listed in the Schedule of Benefits, and described in the Accident or Sickness Medical Benefits section, that the Covered Person incurs during the Benefit Period for Medically Necessary treatment of a covered Injury or Sickness. A Physician must recommend and approve these services or supplies.

Covered Loss means a loss:
1. which is the result of a covered Injury or Sickness to a Covered Person;
2. for which benefits are payable under this Policy; and
3. which is not otherwise excluded under the terms of this Policy.

Covered Person or Insured means an Eligible Person, as defined in the Schedule of Benefits, for whom required premium has been paid when due, and for whom coverage under this Policy remains in force.

Covered Pregnancy means a Pregnancy which began after the effective date of this Policy or the Certificate of Coverage applicable to the Covered Person. Pregnancy which is conceived prior to the Covered Person's effective date under this Policy will be covered if the Covered Person was continuously covered under the Participating Member's plan.

Custodial Care means services and supplies that are primarily intended to help You meet personal needs. Custodial Care must be prescribed by a Physician. It may involve artificial methods such as feeding tubes, ventilators or catheters.

No benefits will be paid for Custodial Care services or treatment which is provided by the Covered Person's Immediate Family Member or by an individual who resides with the Insured, unless specifically agreed to by the Company. Custodial Care does not include Home Health Care services or treatment.

Deductible means the dollar amount of Covered Expenses which must be incurred, as applicable, and paid by the Covered Person before benefits are payable under this Policy. The Deductible may apply to each Covered Person, for each Policy Term, as shown in the Schedule of Benefits.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Departure or Departs means leaving your Home Country or Country of Assignment's air space as specified within this Policy.

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Eligible Dependent: An Eligible Dependent may be the Covered Person's lawful spouse/partner up to Age 70 and/or His unmarried Children under Age 26 who are chiefly dependent upon the Covered Person for support and maintenance. The term "Child/Children" includes a natural Child, a legally adopted Child, a stepchild, and a Child who is dependent on the Covered Person during any waiting period prior to finalization of the Child's adoption and a Child who is dependent on the Covered Person or other care provider(s) for lifetime care and supervision, and incapable of self-sustaining employment by reason of mental or physical handicap that occurred before the Age of 26 (proof will be required). The Eligible Dependent is one who:

1. with a similar visa or passport, accompanies the Covered Person while that person is engaged in international educational activities; and
2. is temporarily located outside the Covered Person's Home Country as a non-resident alien; and
3. has not obtained permanent residency status.

As used above:

1. The term "spouse" means the Covered Person's lawful spouse as defined in the state or jurisdiction where the marriage occurred. This term includes a common law spouse if allowed by the jurisdiction where this Policy is issued.
2. The term "partner" means a Covered Person's spouse or domestic partner.
3. The term "domestic partner" means a person of the same or opposite sex who:
    a. is not married or legally separated;
    b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
    c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;
    d. occupies the same residence as the Covered Person;
    e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
    f. has entered into a domestic partnership arrangement with the Covered Person.
4. The term "domestic partnership arrangement**"** means the Covered Person and another person of the same sex has any three of the following in common:
    a. joint lease, mortgage or deed;
    b. joint ownership of a vehicle;
    c. joint ownership of a checking account or credit account;
    d. designation of the domestic partner as a beneficiary for the Covered Person's life insurance or retirement benefits;
    e. designation of the domestic partner as a beneficiary of the employee's will;
    f. designation of the domestic partner as holding power of attorney for health care; or
    g. shared household expenses.

Emergency means hospitalization or medical care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:

1. permanently placing the Covered Person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy, or
2. causing other serious medical consequences; or
3. causing serious impairment to bodily functions; or
4. causing serious and permanent dysfunction of any bodily organ or part.

Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time shall not be included in this definition of a medical Emergency, unless symptoms suddenly become so severe that immediate medical aid is required.

Emergency Room means a specified area within a Hospital that is designated for Emergency healthcare. This area must:
1. be staffed and equipped to handle trauma;
2. be under the direct supervision of a Physician;
3. provide treatment by a Physician and/or medical professionals; and
4. provided care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Experimental or Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. We will make the final determination as to what is Experimental or Investigative.

Extended Care Facility means an institution operating pursuant to applicable laws and engaged in providing, for a fee, in-patient skilled nursing care and related services and physical therapy services under the supervision of a Physician and Registered Nurses. An Extended Care Facility must maintain medical records on all of its patients.

He, His and Him means the Covered Person who meets the eligibility requirements of this Policy and whose benefits under this Policy are in force.

Health Care Plan means any arrangement, whether individually or group purchased which provides benefits or services for: medical; accident; dental care; disability benefits; or repatriation of remains. A Health Care Plan includes group, blanket, franchise, family or individual:
1. insurance policies;
2. subscriber contracts;
3. uninsured or self-funded agreements or arrangements;
4. coverage provided through: Health Maintenance Organizations; Preferred Provider Organizations; State or Federal Exchanges; Insurance Cooperatives and other prepayment; group practice and individual practice plans;
5. medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a. a state-sponsored Medicaid or similar plan; or
   b. a plan or law proving benefits only in excess of any private or non-governmental plan;
6. hospital or medical service organization;
7. labor-management plans;
8. employee benefit organization plans;
9. association plans; or
10. any other "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended.
11. medical benefits provided under automobile "fault" and "no-fault"–type contracts;
12. other valid and collectible dental, medical or health care benefits or services.

HIV means Human Immunodeficiency Virus, as that term is defined by the United States Centers for Disease Control.

Home Country means the country where a Covered Person has His true, fixed and permanent home and principal establishment and holds a current and valid passport. However, the Home Country of an Eligible Dependent who is a Child is the same as that of the Covered Person.

Home Health Care means nursing care, treatment and items necessary to a person's care and health provided in the Covered Person's house as part of an overall extended treatment plan. To qualify for Home Health Care:

1. the Home Health Care must be established and approved by the attending Physician, including certification that Confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care;
2. nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified agency and nursing service; and
3. the Covered Person's Physician establishes and approves in writing the plan of treatment covering the Home Health Care service.

Home Health Care does not include Custodial Care services or treatment.

Hospital means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate Registered Nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational, long-term acute care or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense and there is a legal obligation to pay.

Hospital Stay means a Confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a covered Accident or Sickness.

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: spouse or domestic partner, brother, brother-in-law, sister, sister-in-law, son, son-in-law, daughter, daughter-in-law, mother, mother-in-law, father, father-in-law, including stepparent, including stepbrother or stepsister, grandparent or grandchild(ren), aunts, uncles, Children, including legally adopted child or stepchild.

Injury or Injuries means any bodily harm that results, directly and independently of all other causes, from a covered Accident. To be covered, the Injury must first be treated while the Covered Person is insured under this Policy. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury. All Injuries sustained in one Accident, including all related conditions and recurrent symptoms of these Injuries will be considered one Injury.

In-Network Provider means a Physician, Hospital and other healthcare providers who have contracted to provide specific medical care at a Negotiated Rate. The availability of specific providers is subject to change without notice. You should always confirm that an In-Network Provider is participating at the time services are provided by asking the provider when You make an appointment for services.

In-Patient means a Covered Person who is Confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to Confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "in-patient" shall mean a Covered Person who is required to be Confined for a period of at least a full day as determined by the Hospital.

Intensive Care Unit means an intensive care facility, cardiac care unit or other unit or area of a Hospital:

1. which is reserved for the critically ill requiring close observation; and

2. which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Covered Person is located at the time of an incident.

Maximum Benefit means the total amount of Covered Expenses that the Company will pay for the Covered Person as shown in the Schedule of Benefits.

Medically Necessary services or supplies are those that We determine to be **all** of the following:
1. appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
2. provided for the diagnosis or direct care and treatment of the medical condition.
3. within standards of good medical practice within the organized community.
4. not primarily for the patient's, the Physician's, or another provider's convenience.
5. the most appropriate supply or level of service that can safely be provided. For Hospital Stays, this means acute care as an In-Patient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an Out-Patient or in a less intensified medical setting.
6. not Experimental or Investigational unless approved in writing by Us.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by this Policy.

Mountaineering means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Negotiated Rate means the compensation for medical services provided by an In-Network Provider which the In-Network Provider has agreed to accept as full compensation for medical services covered under this Policy.

Out-of-Network Provider means a Physician, Hospital and other healthcare providers who have not agreed to a Negotiated Rate. A Covered Person may incur Out-of-Pocket expenses with these providers. Charges in excess of the Company's payment are the Covered Person's responsibility.

Out-Patient means a Covered Person who receives Medically Necessary treatment on an Out-Patient basis in a Hospital or another institution, including; Ambulatory Surgical Center; convalescent/Skilled Nursing Facility; or Physician's office, for an Injury or Sickness, but who is not Confined and is not charged for room and board.

Out-of-Pocket Maximum means the maximum dollar amount the Covered Person is responsible to pay during this Policy Term. After the Covered Person has reached the Out-of-Pocket Maximum, this Policy pays 100% of Covered Expenses up to the maximums shown in the Schedule of Benefits for the remainder of this Policy. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Copayments. Penalties and amounts above the Usual and Customary Charge do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Parachuting means an activity involving the breaking of a free fall using a parachute or other device that slows free fall.

Participation in Riot or Civil Commotion. "Participation" means promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen. "Riot or Civil Commotion" means all forms of public violence, disorder, or disturbance, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or consequence of such disorder.

Physician means a person who is a qualified practitioner of medicine. As such, He must be acting within the scope of his license under the laws in the state in which he practices and providing only those medical services which are within the scope of his license or certificate. It does not include a Covered Person, an Immediate Family Member of either the Covered Person or the Covered Person's spouse.

Physical Therapy or Physiotherapy In-Patient means any form of the following administered by a Physician: (1) physical or mechanical therapy to match expiring policy, (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; (5) acupuncture, (6) microthermy, (7) chiropractic adjustment, (8) whirlpool, or (9) manipulation or massage

Physical Therapy or Physiotherapy Out-Patient means any form of the following administered by a Physician: (1) physical or mechanical therapy to match expiring policy, (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; (5) acupuncture, (6) microthermy, (7) chiropractic adjustment, (8) whirlpool, or (9) manipulation or massage.

Policyholder means SMIC Trust

Policy Term or Policy Year means the period of a year or less, and any subsequent period of a year or less, that an Eligible Person is covered under this Policy, in accordance with a Certificate of Coverage, provided the premium is paid according to the agreed terms.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 3 month period immediately prior to the date the Covered Person's coverage is effective for which the Covered Person: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. (2) does not apply to a condition which is treated or controlled solely through the taking of prescriptions drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 3 month period before coverage is effective under this Policy.

Pregnancy which is conceived prior to the Insured's effective date under this Policy will be covered if the Insured was continuously covered under the Participating Member's plan.

Pregnancy means the physical condition of being pregnant, including Complications of Pregnancy.

Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students for a minimum of 20 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses or Injuries and/or referral to an In-Network Provider and is approved as a Recognized Student Health Center by the Participating Member.

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." or "R. P.N." after His name.

Rehabilitation Facility means a legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which:

1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services, occupational therapy, speech therapy or rehabilitation In-Patient care; and
2. is duly licensed by the appropriate government agency to provide such services; and
3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

A Rehabilitation Facility does not include institutions which provide only minimal care, Custodial Care, care for the terminally ill, part-time care, or services or facilities for Drug Abuse or alcoholism.

Sickness or Sicknesses means an illness, disorder, pathology, abnormality, ailment, disease or any other medical physical or health condition of a Covered Person, which requires treatment by a Physician while covered by this Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be prescribed by a Physician and directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Substance Abuse means the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining Covered Expenses, charges made for the treatment of any physiological conditions related to rehabilitation services for Alcohol & Drug Abuse or addiction will not be considered charges made for treatment of Substance Abuse.

Surgical Procedure means:
1. a cutting procedure;
2. suturing a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. electrocauterization;
6. diagnostic and therapeutic endoscopic procedures; and
7. an operation by means of laser beam.

Third Party means a person or entity other than the Covered Person, the Participating Member or the Company.

United States (U.S.) means the 50 states of the United States of America, and the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Usual and Customary Charge (U&C) means the normal charge, in the absence of insurance, made by the provider of any Medically Necessary treatment, but not more than the prevailing charge in the area:
1. for a like service by a provider with similar training or experience; or
2. for a supply that is identical or substantially equivalent.

War means a state or period of declared or undeclared War whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states, or parties. War or acts of War does include acts of terrorism.

We, Our, Us means The Pan-American International Insurance Corporation, (A Stock Company) underwriting these benefits.

You, Your means the Covered Person who meets the eligibility requirements of this Policy and whose benefits under this Policy are in force.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility
A person is eligible for benefits under this Policy when He meets the definition of an Eligible Person shown in the Schedule of Benefits.

Enrollment for Coverage:
A Covered Person and their Eligible Dependent(s) will be eligible for coverage under this Policy subject to the particular types and amounts of benefits. If Eligible Dependent coverage is elected by a Covered Person, a Covered Person may also enroll His Eligible Dependent(s) for coverage on the later of:
1. the effective date of His benefits; or
2. within 31 days from the date on which the Eligible Dependent(s) Departs from His Home Country.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

Effective Date for a Covered Person
Coverage for a Covered Person that will be covered by this Policy starts at 12:00 AM on:
1. the date the requirements of a Covered Person shown in the Schedule of Benefits are met; or
2. the moment He Departs His Home Country's airspace

Thereafter, the benefits are effective 24 hours a day.

Termination Date for a Covered Person
Coverage for Covered Person will automatically terminate on the earliest of the following dates:
1. the date this Policy terminates;
2. the date the Participating Member is no longer eligible to sponsor coverage under this Policy;
3. the date on which the Covered Person ceases to meet the requirements of an Eligible Person shown in the Schedule of Benefits;
4. the date the Covered Person permanently leaves the Country of Assignment for His Home Country;
5. the date the Covered Person requests cancellation of coverage (the request must be in writing);
6. the premium due date for which the required premium has not been paid, subject to the Grace Period provision; or
7. the end of any period of coverage.

Coverage will end at 11:59 PM on the last date of benefits. Termination does not affect a claim for a Covered Loss due to a covered Accident or Sickness that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:
1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit, as shown in the Schedule of Benefits, have been paid

Effective Date for an Eligible Dependent
An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, or during an open enrollment. An Eligible Dependent's coverage starts at 12:00 AM on the effective date of the Covered Person's benefits.

Thereafter, the benefits are effective 24 hours a day.

Termination Date for an Eligible Dependent
An Eligible Dependent's coverage automatically ends on the earliest of the following dates:
1. the date this Policy terminates;
2. the date the Participating Member is no longer eligible to sponsor coverage under this Policy;
3. the date the Covered Person is no longer covered under this Policy;

4. the date of which the Covered Person ceases to meet the requirements of an Eligible Person shown in the Schedule of Benefits;
5. 11:59 PM on the date He permanently Departs the Country of Assignment for His Home Country;
6. the date the Covered Person requests cancellation of coverage (the request must be in writing);
7. the premium due date for which the required premium has not been paid, or
8. the date on which the Eligible Dependent ceases to meet the requirements of an Eligible Person shown in the Schedule of Benefits.

Coverage will end at 11:59 PM on the last date of benefits. Termination does not affect a claim for a Covered Loss due to a covered Accident or Sickness that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:

1. the end of the Benefit Period;
2. the date benefits equal to any applicable Benefit Limit, as shown in the Schedule of Benefits, have been paid.

COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN OR FOSTER CHILDREN

Coverage of Newborn Infants A newborn child of the Covered Person who is eligible for maternity benefits will automatically be a Covered Person for 31 days from the moment of His birth if the birth occurs while this Policy is in force. Coverage will terminate after the first 31 days from the moment of birth and subject to the particular coverages and amounts of benefits as specified in the Schedule of Benefits. You must give Us notice within 31 days of the birth of the child. If notice is not given within 31 days, coverage for the newborn child will terminate upon the expiration of the initial 31-day period.

Coverage of Adopted or Foster Children
Coverage for an adopted or foster Child ages under 18, other than a newborn, of the Covered Person will begin from the date of placement in the Covered Person's home for the purpose of adoption or fostering for the date of entry of an interim court order granting temporary custody of the Child, whichever comes first. A notice of placement for adoption or fostering must be submitted to Us. If notice is not given within 30 days, coverage for the adopted or foster Child will terminate upon the expiration of the initial 31-day period.

It is the Covered Person's responsibility to maintain all records regarding travel history, Age and provide any documents to the Participating Member, which would verify Eligibility Requirements.

COVERAGE FOR SPORTS RELATED INJURIES

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, when the Covered Person suffers a covered Injury resulting directly and independently of all other causes from a covered Accident that occurs while He is participating in one of the following Covered Activities:

> **Amateur, Intercollegiate, Club and Interscholastic Athletic Sports Conditions** include: Baseball; Basketball; Cheerleading; Competitive Cycling (Road, Track, CX); Cross Country; Diving; Equestrian; Fencing; Field Hockey; Football (no Division One); Golf; Gymnastics; Ice Hockey; Lacrosse; Martial Arts; Polo Horse; Polo Water; Rugby; Skiing (Slalom, Giant Slalom, Downhill); Soccer; Softball; Swimming; Tennis; Track and Field; Volleyball; Wrestling.

DESCRIPTION OF ACCIDENT OR SICKNESS MEDICAL EXPENSE BENEFITS

This Section describes the Scope of Coverage for which Medical Benefits are payable and the *Accident or Sickness Medical Expense Benefits* provided by this Policy. Any applicable Benefit Percentages, Coinsurance, Copayments, Deductibles, Benefit Periods, Out-of-Pocket Maximums, Benefit Limits and Maximums are shown in the Schedule of Benefits. Please read these and the *Exclusions* Section in order to understand all of the terms, conditions and limitations applicable to these benefits.

SCOPE OF COVERAGE APPLICABLE TO MEDICAL EXPENSE BENEFITS

Covered Expenses and any applicable Policy Aggregate Deductible and specific benefit Coinsurance, Copayments, Deductibles, Benefits Periods, Out-of-Pocket Maximum, Benefit Limits and Benefit Maximums are shown in the Schedule of Benefits.

Other Health Care Plan Benefits
When another Health Care Plan provides benefits in the form of services rather than cash payments, We will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

Coordination of Benefits:
If a Covered Person has medical and/or drug coverage under any other Health Care Plan, all of the benefits provided are subject to coordination of benefits. During any Policy Year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Health Care Plan will not be more than the Allowable Expenses.

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

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

Benefit Determination Rules
This Policy determines its order of benefits using the first of the following rules which applies:

1) If the Covered Person's other Health Care Plan does not have Coordination of Benefits, that Health Care Plan pays first.
2) Non-Dependent/Dependent: The benefits of the Health Care Plan which covers the person as an employee, member or subscriber are determined before those of the Health Care Plan which covers the person as a Dependent.
3) Dependent Child/Parents Not Separated or Divorced: When this Policy and another Health Care Plan cover the same Child as a Dependent of different persons, called "parents":
   a. the benefits of the Health Care Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Health Care Plan of the parent whose birthday falls later in that year; but
   b. if both parents have the same birthday, the benefits of the Health Care Plan which covered the parent longer are determined before those of the Health Care Plan which covered the other parent for a shorter period of time.
   c. However, if the other Health Care Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Health Care Plans do not agree on the order of benefits, the rule in the other Health Care Plan will determine the order of benefits.
4) Dependent Child/Separated or Divorced Parents: If two or more Health Care Plans cover a person as a dependent Child of divorced or separated parents, benefits for the Child are determined in this order:
   1. first, the Health Care Plan of the parent with custody of the Child;
   2. then, the Health Care Plan of the spouse of the parent with the custody of the child; and
   3. finally, the Plan of the parent not having custody of the child.

5) Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the Health Care Plan which covered the individual longer are determined before those of the Health Care Plan which covered that individual for the shorter time.

The actual benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Policy will never exceed the amount that would have been paid if there were no other plans involved. If benefit payments under this Policy are reduced by Coordination of Benefits, only the reduced amounts will be charged against the Covered Person's plan maximums.

Facility of Payment and Recovery - If during Coordination of Benefits, payments are made in error, the plans will have the right to adjust payments among themselves. Such payments satisfy the Company's liability. If a claim is overpaid under this Policy, the Company has the right to recover such overpayments from any individual for, to whom, or with respect to whom such payments were made, any other insurance company, or any other organization.

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

Definitions for the purpose of this Coordination of Benefits section:

Allowable Expenses means any Medically Necessary, Usual and Customary Charge, a part of which is covered by at least one of the Health Care Plans covering the Covered Person. When benefits from a Health Care Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

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

Primary means the Health Care Plan which pays regular benefits.

Secondary means the Health Care Plan which pays a reduced amount of benefits which, when added to the Primary Health Care Plan's benefits will not be more than the Allowable Expenses.

EXTENSION OF BENEFITS

During Hospital Confinement Upon Policy Cancellation

If the Accident or Sickness Medical Benefits under this Policy cease for You or Your Eligible Dependent due to cancellation of the Policy or any Certificate of Coverage issued thereunder (except if the Policy or Certificate of coverage is canceled for nonpayment of premiums) and You or Your Eligible Dependent is Confined in a Hospital on that date, Accident or Sickness Medical Benefits will be paid, as shown in the Schedule of Benefits, for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

1. the date You exceed the Maximum Benefit, if any, shown in the Schedule of Benefits;
2. the date You are covered for medical benefits under another Health Care Plan;
3. the date You or Your Dependent is no longer Hospital Confined; or
4. 30 days from the date this Policy or the Certificate of Coverage thereunder applicable to You is canceled.

The terms of this Accident or Sickness Medical Benefits Extension will not apply to a child born as a result of a Pregnancy which exists when Your Accident or Sickness Medical Benefits cease or Your Eligible Dependent's Accident or Sickness Medical Benefits cease.

ACCIDENT OR SICKNESS MEDICAL EXPENSE BENEFITS

We will pay the benefits shown in the Schedule of Benefits for Covered Expenses incurred by the Covered Person, subject to all applicable conditions and exclusions, for Medically Necessary treatment of a covered Sickness or Injury that resulted directly and independently of all other causes from a covered Accident or Sickness.
Benefits will be paid:

1. when Covered Expenses incurred exceed any applicable Policy Aggregate, Coinsurance, Copayments, Out-of-Pocket Maximums and individual Deductible within the number of days from the date of the covered Accident or Sickness specified in the Schedule of Benefits*;* and
2. until any applicable Benefit Period shown in the Schedule of Benefits has expired; and
3. until the total of Covered Expenses paid equals any applicable Benefit Limit or Maximum Benefit shown in the Schedule of Benefits; and
4. until Benefits paid for all Covered Persons under the Policy equal the Total Maximum for Accident or Sickness Medical Expense Benefits shown in the Schedule of Benefits.

MEDICAL EXPENSE BENEFITS

Covered Expenses

AMBULANCE SERVICES
We will pay Covered Expenses incurred for ground or air ambulance service to transport the Covered Person from the place where the covered Accident or Sickness occurred to the nearest medically appropriate facility. We will pay Covered Expenses incurred for ground or air ambulance transportation from the nearest medical facility to another appropriate medical facility if a Physician specifies in writing that specialized care not available in the first facility to which the Covered Person was transported is necessary to treat His covered Injury.

AMBULATORY MEDICAL OR SURGICAL CENTER
We will pay Covered Expenses incurred for medical or surgical treatment provided in a licensed facility providing ambulatory medical or surgical treatment that is not a Hospital or Physician's office.

BEHAVIORAL HEALTH SERVICES EXPENSE BENEFIT
Behavioral health services are the evaluation, management, and treatment of a Covered Person with a mental health or Substance Abuse disorder.

For the purposes of this Policy mental health disorder shall be defined as mental illness. Mental illness means:

- Any mental disorder and substance use disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization;
- Substance Use disorder does not include addiction to or abuse of tobacco and/or caffeine.

Mental disorders are covered under **Mental and Nervous Disorders** as stated within the Schedule of Benefits.
Substance use disorders are covered under **Substance Abuse; or Alcohol & Drug Abuse Expense Benefit** as stated within the Schedule of Benefits.

A. Mental Health Services
This Policy covers Medically Necessary services for the treatment of mental health disorders in a general or specialty Hospital or Out-Patient facilities that are:

- licensed under the laws by the state in which the facility is located as a general or specialty Hospital or Out-Patient facility.

We reserve the right to review In-Network and Out-of-Network programs, Hospitals and In-Patient facilities, and the specific services provided to decide whether a program, Hospital or In-Patient facility, or specific services rendered meets

Our program requirements, content and criteria. If Our program content and criteria are not met, the services are not covered under this Policy. Our program content and criteria are defined below.

In-Patient
If the Covered Person is an In-Patient in a general or specialty Hospital for mental health services, this Policy covers Medically Necessary Hospital services and the services of an attending Physician for the number of Hospital days shown in the Schedule of Benefits.

Intermediate Care Services
Intermediate Care Services are facility-based programs used as a step down from a higher level of care or a step-up from standard care.

This Policy covers the following Medically Necessary Intermediate Care Services for mental health:

- **Partial Hospital Program (PHP)** – This Policy covers partial Hospital programs that meet Our criteria for participation and program requirements.
- **Intensive Out-Patient Program (IOP)** – This Policy covers intensive Out-Patient programs that meet Our criteria for participation and program requirements.

In a Provider's Office
This Policy covers the following mental health specialists:

- Board certified psychiatrists;
- Licensed clinical psychologists;
- Clinical social workers (licensed or certified at the independent practice level);
- Licensed nurse clinicians (with a Master's degree in nursing and certification by the ANA as a clinical specialist in psychiatric and mental health nursing);
- Licensed mental health counselor

The above providers must be licensed and certified in the state where You receive the service and must meet Our credentialing criteria.

Covered mental health services include Medically Necessary individual psychotherapy, group psychotherapy, and family therapy, when rendered by the appropriate mental health specialist, as listed above.

Psychological testing and neuropsychological testing are covered when Medically Necessary and rendered by a neuropsychologist, psychologist, or pediatric neurodevelopmental specialist.

This Policy covers medication visits when rendered by a psychiatrist or a clinical nurse specialist in behavioral health.

B. Substance Use Disorder Treatment
This Policy covers Medically Necessary services for the treatment of substance use disorder in a Hospital, substance use disorder treatment facility, or an acute substance use disorder Rehabilitation Facility or residential facility that is licensed under the laws by the state in which the facility is located as a Hospital, a substance use disorder treatment facility, or an acute substance use disorder residential/rehabilitative facility.

In-Patient Hospital
If the Covered Person is an acute In-Patient in a general or specialty Hospital for behavioral health services, We cover Medically Necessary acute Hospital services for detoxification.

Substance Use Disorder Treatment/Intermediate Care Services
This Policy covers services for the treatment of substance use disorder for individuals and family members covered under this Policy when rendered at a substance use disorder treatment facility or a state-licensed provider/program.

Intermediate Care Services are facility-based programs used as a step down from a higher level of care or a step-up from standard Out-Patient care.

This Policy covers the following Medically Necessary Intermediate Care Services for substance use disorder:

- **Partial Hospital Program (PHP)** – This Policy covers partial Hospital programs that meet Our criteria for participation and program requirements.
- **Intensive Out-Patient Program (IOP)** – This Policy covers intensive Out-Patient programs that meet Our criteria for participation and program requirements.

In a Provider's Office
This Policy covers services for the treatment of substance use disorder for Covered Person's covered under this Policy. The services may be rendered in a provider's office.

This Policy covers the following behavioral health specialists:

- Psychiatrists;
- Licensed independent clinical psychologists;
- Clinical social workers (licensed or certified at the independent practice level);
- Licensed nurse clinicians (with a Master's degree in nursing and certification by the ANA as a clinical specialist in psychiatric and mental health nursing);
- Licensed mental health counselor;

The above providers must be licensed and certified in the state where You receive the service. Covered substance use disorder services include Medically Necessary individual evaluation and psychotherapy, group psychotherapy, and family therapy when rendered by a behavioral health specialist, as listed above.

CONTRACEPTIVE DRUGS AND DEVICES
We will pay Covered Expenses incurred for all of the following services and contraceptive methods for women:

a. All FDA-approved contraceptive drugs, devices and products as prescribed by the enrollee's provider;
b. Voluntary sterilization procedures;
c. Patient education and counseling on contraception;
d. Follow-up services related to the drugs, devices, products and procedures covered under this benefit, including, but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

DENTAL SERVICES
We will pay Covered Expenses incurred for dental treatment, including X-rays, for injury to a natural tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For benefit review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.
4. repair to sound, natural teeth

Covered Expenses include examinations, x-rays, restorative treatment, endodontics, oral surgery, initial braces required for treatment of a covered Injury and treatment of gingivitis resulting from trauma.

If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

EMERGENCY ROOM AND EMERGENCY ROOM TREATMENT
We will pay Covered Expenses incurred for Out-Patient Emergency Room and Emergency Room Treatment performed in a Hospital, up to the Maximum Benefit shown in the Schedule of Benefits. Covered Expenses charged by the Emergency Room Physician and related x-ray/laboratory interpretations are included under this benefit.

HOSPITAL MISCELLANEOUS EXPENSES IN-PATIENT
We will pay the miscellaneous expenses charged by a Hospital. Miscellaneous expenses include, but are not limited to operating room, X-rays, laboratory tests, anesthesia, drugs (excluding take-home drugs) or medicines, supplies, therapeutic services, blood and blood transfusions (blood storage not included), tests and procedures and all necessary charges other than room and board, for services received during a Hospital Stay.

Miscellaneous expenses do not include personal supplies and services, such as barber or beautician services, telephone charges, transportation, guest meals, radio or television, extra beds or cots, meals for guests, take home items or other convenience items when provided during a Hospital Stay.

HOSPITAL MISCELLANEOUS EXPENSES OUT-PATIENT
We will pay the miscellaneous expenses charged by a Hospital. Miscellaneous expenses include, but are not limited to operating room, X-rays, laboratory tests, nurse services, anesthesia, drugs or medicines, supplies, therapeutic services, tests and procedures and all necessary charges other than room and board, for services received during Out-Patient medical or surgical treatment.

IN-PATIENT HOSPITAL SERVICES
We will pay Covered Expenses for:

1. Confinement in an intensive care or coronary care unit for each day of such Confinement this includes nursing services;
2. any other Confinement for each day of the Hospital Stay.
3. Room and Board Expenses
4. The daily room rate for a private/semi-private room when a Covered Person is confined in a Hospital and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Treatment of Mental and Nervous disorders is not covered as a Hospital service if treatment is provided in a Hospital.

OUT-PATIENT LABORATORY TESTS
We will pay Covered Expenses incurred for laboratory tests performed on an Out-Patient basis at a Hospital or other licensed facility.

OUT-PATIENT X-RAYS
We will pay Covered Expenses incurred for X-rays, except dental X-rays, performed on an Out-Patient basis at a Hospital or other licensed facility.

PEDIATRIC DENTAL
We will pay Covered Expenses incurred for necessary dental treatment for an Eligible Dependent who has not reached the age of 19. Treatment must be provided by, or under the direction, of a Dentist. A Covered Expense is considered incurred on the date the service is rendered or the supply is furnished by the Dentist.

PEDIATRIC VISION
We will pay Covered Expenses incurred for Pediatric Vision expenses for an Eligible Dependent who has not reached the age of 19.

PHYSICAL THERAPY IN-PATIENT
We will pay Covered Expenses incurred for In-Patient Physical Therapy. Physical Therapy includes: (1) physical or mechanical therapy to match expiring policy, (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; (5) acupuncture, (6) microthermy, (7) chiropractic adjustment, (8) whirlpool, or (9) manipulation or massage.

PHYSICAL THERAPY OUT-PATIENT
We will pay Covered Expenses incurred for Out-Patient Physical Therapy. Physical Therapy includes: (1) physical or mechanical therapy to match expiring policy, (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; (5) acupuncture, (6) microthermy, (7) chiropractic adjustment, (8) whirlpool, or (9) manipulation or massage.

PRE-EXISTING CONDITIONS
We will pay Covered Expenses incurred for diagnosis or treatment as shown in the Schedule of Benefits.

PREGNANCY, COMPLICATIONS OF PREGNANCY, MATERNITY AND PRE-NATAL EXPENSE BENEFIT
We will pay Covered Expenses incurred, to a Covered Person, as a result of maternity, Pregnancy, childbirth, miscarriage, or any Complications of Pregnancy resulting from any of these, to the extent shown in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Covered Expenses during any one period of individual coverage.

Pregnancy which is conceived prior to the Insured's effective date under this Policy will be covered if the Insured was continuously covered under the Participating Member's plan.

Benefits will be payable for Covered Expenses a Covered Person incurs before, during, and after delivery of a child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the In-Patient postpartum stay for the Covered Person and her newborn child in a Hospital will cover a period of hospitalization for maternity and newborn infant care for:

a. a minimum of 48 hours of In-Patient care following a vaginal delivery; or
b. a minimum of 96 hours of In-Patient care following delivery by cesarean section.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Covered Person's attending Physician determines further In-Patient postpartum care is not necessary for the Covered Person or her newborn child provided the following are met:

1) In the opinion of the Covered Person's attending Physician, the newborn child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
   a) The antepartum, intrapartum, postpartum course of the mother and infant;
   b) The gestational stage, birth weight, and clinical condition of the infant;
   c) The demonstrated ability of the mother to care for the infant after discharge; and
   d) The availability of post discharge follow up to verify the condition of the infant after discharge; and

2) One (1) at-home post delivery care visit is provided to the Covered Person at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Covered Person and her newborn child from the Hospital. Coverage for this visit includes, but is not limited to:
   a) Parent education;
   b) Assistance in training in breast or bottle feeding; and
   c) Performance of any maternal or neonatal tests routinely performed during the usual course of In-Patient care for the Covered Person or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Covered Person's discretion, this visit may occur at the Physician's office.)

PHYSICIAN SERVICES
We will pay Covered Expenses incurred for physician services listed below.

Surgery
1. Covered Expenses charged for performing a Surgical Procedure. Two or more Surgical Procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. However, We will

pay for the most expensive procedure and up to 50% of the benefit for a Surgical Procedure when more than one Surgical Procedure through different operating fields is performed during the same surgical session.
2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a Surgical Procedure.
3. Surgeon fees for performing the surgery.

Second Opinion or Consultation – Covered Expenses charged by a Physician for a second or third surgical opinion or consultation. Covered Expenses will be paid under this benefit or under the Physician's Visits benefit, but not both on the same day.

Anesthesia and its Administration – Covered Expenses for pre-operative screening charged by a Physician for anesthesia and its administration during a Surgical Procedure whether on an In-Patient or Out-Patient basis.

In-Hospital Visits or Out-Patient Office Visits – Covered Expenses charged by a Physician for other than pre- or post-operative care, second or third opinion or consultation:
1. for in-Hospital visits; and
2. for office visits.

PRE-ADMISSION TESTING

We will pay Covered Expenses charged for pre-admission testing (In-Patient Confinement must occur within 3 days of the testing).

PRESCRIPTION DRUGS

We will pay the Covered Expenses incurred for drugs that:
1. can only be obtained through a Physician's written prescription; and
2. are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay Covered Expenses incurred for drugs that meet 1. above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay Covered Expenses incurred by a Covered Person, for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:
1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
2) the drug is approved by the FDA for use in antineoplastic therapy;
3) the drug is used as part of an antineoplastic drug regimen;
4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
5) the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

REHABILITATIVE BRACES AND APPLIANCES

We will pay Covered Expenses for rehabilitative braces and appliances prescribed by a Physician. It must be durable medical equipment that has therapeutic value for the Covered Person that: (1) is primarily and customarily used to serve a medical purpose; (2) can withstand repeated use; and (3) generally is not useful to a person in the absence of the covered Injury or Sickness.

Benefits will not be paid for:
1. Rental charges in excess of the purchase price.
2. For the replacement of durable medical equipment.

URGENT CARE

We will pay Covered Expenses incurred for treatment of short-term medical care for non-life threatening conditions.

WELLNESS EXPENSE BENEFIT
We will pay Covered Expenses as per the limits stated in the Schedule of Benefits. Medical Expense Benefits are limited to the following expenses incurred and are subject to the Exclusions. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered Wellness Expenses Benefits include:

1. Routine physical examinations
2. Preventive Treatment
3. Annual cervical cytology screening for women
4. Low dose mammography screening and one baseline mammogram per year
5. Colorectal cancer screenings
6. Immunizations indicated on the Recommended Immunization Schedule by the Centers for Disease Control and Prevention
7. Prostate and/or colorectal examinations and related laboratory tests
8. Gynecologic health screenings

GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ACCIDENT OR SICKNESS MEDICAL EXPENSE BENEFITS

Limitation for Sports Injuries
Benefits will be paid for Covered Expenses incurred for treatment of covered Injuries that result directly and independently of all other causes from a covered Accident that occurred while the Covered Person was participating in any covered sports related activity as shown in the **COVERAGE FOR SPORTS RELATED INJURIES** provision. Benefits will not exceed the Benefit Limit shown in the Schedule of Benefits.

Limitation for Motor Vehicle Accidents
Benefits will be paid for Covered Expenses incurred for treatment of covered Injuries that result directly and independently of all other causes from a covered Accident that occurred while the Covered Person was riding in or driving a motor vehicle. Benefits will not exceed the Benefit Limit shown in the Schedule of Benefits.

Non-Duplication of Benefits
This provision applies if:

1. any other Health Care Plan covers the Covered Person; and
2. total benefits under all Plans would exceed the Covered Expenses actually incurred; and
3. We are not defined as primary under another Health Care Plan's Coordination of Benefits provision.

When the total of benefits payable by all Health Care Plans, whether or not claim is made for those benefits, exceeds Covered Expenses incurred, any Expense-Incurred Accident or Sickness Benefits We pay will be reduced by such excess.

Non-Duplication of Benefits When This Policy and Other Plans Are Excess
This provision applies if benefits under any other Health Care Plan are covered under this Policy, and coverage under this Policy and the other Plan are excess. We pay a pro rata share of the total amount of Covered Expenses. In no case will the total benefits payable exceed 100% of the Covered Expenses. Our pro rata share equals the total of benefits payable under this Policy multiplied by a fraction, of which the numerator is the benefits We pay and the denominator is the total of benefits payable by all Health Care Plans for the same covered Accident or Sickness.

Multiple Coverages
The Covered Person is not eligible for blanket Accident or Sickness benefits under more than one policy issued by Us. If premium is being paid under more than one such policy, benefits will be in effect under the policy providing the greatest benefit, and premium paid under any other policies will be refunded.

GENERAL EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any covered Injury or Sickness, Covered Loss, Covered Expense which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in this Policy:

1. Intentionally self-inflicted Injury, suicide or any attempt thereat, including drug overdose, self-destruction, attempted self-destruction, while sane or insane in excess of the amount as shown in the Schedule of Benefits.
2. Commission or attempt to commit a felony or an assault or other illegal activity.
3. Commission of or active Participation in a Riot, Civil Commotion or insurrection.
4. Injury sustained while taking part in caving or spelunking, Mountaineering, hang gliding, Parachuting, parasailing, bungee jumping, racing by any animal, snowmobiling, motorcycle/motor scooter riding (whether as a passenger or driver), scuba diving involving underwater breathing apparatus (unless SSI, PADI or NAUI certified), water skiing, jet skiing, snow skiing, snowboarding, solo diving, snorkeling, white water rafting, surfing, unless part of a school credit course and any sport or athletic activity which is undertaken for thrill seeking and exposes You to abnormal or extreme risk of injury.
5. Declared or undeclared War or acts of War.
6. Travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle; when used for recreation or competition, snowmobile, water jet ski, two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel.
7. Participation in any motorized race or contest of speed.
8. An Accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Covered Person holds a valid learner's permit and (b) the Covered Person is receiving instruction from a Driver's Education Instructor.
9. The Covered Person being legally Intoxicated as determined according to the laws of the jurisdiction in which the covered Accident or Sickness occurred.
10. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.
11. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Participating Member.
12. A covered Accident or Sickness that occurs while on active duty service in the Armed Forces, National Guard, military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time.
13. Practice or Play in any professional or semi-professional sports activity, including travel to and from the activity and practice.
14. Play or practice in any amateur, club, intercollegiate, interscholastic, intramural sports contest or competition, including travel to and from the activity and practice unless specified within the Schedule of Benefits.
15. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means Intoxicated, as defined by the law of the state in which the covered Accident or Sickness occurred. If such jurisdiction does not have a law to define Intoxication, then under this Policy it will mean a blood alcohol content of .08 or greater.
16. Services or treatment rendered by any person who is:
    a.) employed or retained by the Participating Member; b.) living in the Covered Person's household; c.) an Immediate Family Member of either the Covered Person or the Covered Person's spouse; or d.) the Covered Person.
17. Any service, treatment or supply that is not considered Medically Necessary as defined in this Policy.
18. Expenses Incurred after the end of the Benefit Period, even if incurred for continuing services or treatment of a covered Injury or Sickness.
19. Eyeglasses, contact lenses, hearing aids, braces, appliances, or prescriptions therefore.
20. Rest cures or Custodial Care.
21. Expenses payable by any automobile insurance policy without regard to fault resulting from a motor vehicle accident in excess of that which is payable under any Health Care Plan.

22. Unless specifically provided for elsewhere in this Policy, the cost of treatment or services that are provided at no cost to the Covered person, normally without charge by the Covered Person's Recognized Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Participating Member, including team doctors and trainers or any other service performed at no cost.
23. Organ transplants; medical treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges.
24. Expenses incurred for treatment of temporomandibular joint (TMJ) disorders or craniomandibular joint dysfunction and associated myofascial pain.
25. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to the date the Covered Person's coverage is in effect under this Policy, unless We receive a written medical release from the Covered Person's Physician.
26. Treatment of HIV infection, HIV related illness and AIDS unless specified in the Schedule of Benefits.
27. A covered Accident or Sickness that occurs while the Covered Person's in their Home Country.
28. Treatment or services provided by a private duty nurse.
29. Routine physical exams, annual eye exams, and medical services or wellness visits except as specifically provided for in this Policy.
30. Treatment of hernia (including sports hernia whether or not caused by a covered Accident).
31. Covered Expenses for which the Covered Person would not be responsible for in the absence of this Policy.
32. Any Medical Expense not specifically covered by this Policy.
33. Expenses for dental services and palliative services unless specified in the Schedule of Benefits.
34. Experimental or Investigational treatment or procedures and treatment not recognized and generally accepted medical practice in the United States unless otherwise noted in the Schedule of Benefits.
35. Expenses resulting from a motor vehicle accident in excess of that which is payable under any valid and collectible insurance.
36. Duplicate services provided by both a certified nurse, midwife and Physician.
37. Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician.
38. Drug, treatment or procedure that promotes childbirth, including but not limited to artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof.
39. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident or emergency pain relief treatment to natural teeth while the Covered Person is covered under the Policy and rendered within 6 months of the Accident.
40. Foot care including flat foot conditions; corns; calluses; toenails; weak feet.
41. Expenses incurred during a Hospital Emergency Room visit which is not of an Emergency nature.
42. Weight reduction programs or surgical treatment of obesity.
43. Elective or Cosmetic Surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body. Correction of a deviated nasal septum is considered Cosmetic Surgery unless it results from a covered Injury or Sickness.
44. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or b) While being used for any test or experimental purpose; or c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Participating Member of any subsidiary or affiliate of the Participating Member, or by the Plan Participant or any member of his household; or e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or f) An ultra light, hang gliding, Parachuting or bungee-cord jumping. Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
45. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.
46. Covered Person being exposed to the utilization of nuclear, chemical or biological weapons of mass destruction.

47. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency.
48. Health spa or similar facilities; strengthening programs.
49. Pre-existing Conditions in excess of $2,500 except for a Covered Person who has been continuously insured for at least 3 consecutive months under this Policy or the Participating Member's plan.
50. 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.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice must be given to Us or Our authorized agent within 30 days after a covered Accident or Sickness occurs or the loss begins or as soon as reasonably possible, but in no case any longer than 12 months after the date of loss. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Participating Member's name and Member Plan Number and the Covered Person's name and address.

Claim Forms
We send forms for filing proof of loss when We receive the notice of claim. If claim forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than 12 months after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims
We will pay benefits due under this Policy for any loss, other than a loss for which this Policy provides any periodic payment, immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefit descriptions. Any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us, unless otherwise stated in this Policy.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to His estate. If any payee of benefits is a minor or otherwise legally incompetent, We will pay benefits to the person designated as His legal guardian or conservator.

We may, at Our option, pay any Accident or Sickness Medical Benefits directly to a health care provider that renders services to the Covered Person, unless the Covered Person requests in writing when submitting the claim that such payment not be made to the provider.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability for that payment.

Beneficiary
The beneficiary is the person or persons the Covered Person names or changes on a form executed by Him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Participating Member. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at Our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to Him, We may make direct payment to the first surviving class of the following classes of persons:

1. Spouse or domestic partner;
2. Child or Children;
3. parents;
4. siblings;
5. estate of the Covered Person.

Conditional Claim Payment
If the Covered Person incurs Covered Expenses for covered Injuries received in a covered Accident or Sickness and it is likely a Third Party may be liable, We will pay benefits if:

1. the Covered Person first agrees in writing to refund the lesser of:
    a. the amount We actually paid for such Covered Expenses; and
    b. the amount actually received from the Third Party regardless of whether the amount is for such Covered Expenses; and
2. the Third Party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise. However, if the Third Party's liability is satisfied in an amount less than the benefits paid under this Policy, We will pay the difference.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

Right of Recovery of Overpayment or Error: Whenever the Company has made payments with respect to benefits payable under this Policy in excess of the amount necessary, We shall have the right to recover such payments. The Company shall notify the Covered Person or health care provider of such overpayment and request reimbursement from the Covered Person or health care provider. However, should the Covered Person or health care provider not provide such

reimbursement, the Company has the right to offset such overpayment against any other benefits payable to the Covered Person or health care provider under this Policy to the extent of the overpayment.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

Subrogation
We have the right to recover all payments including future payments, which We have made, or will be obligated to pay in the future, to the Covered Person from anyone liable for the Covered Loss. If the Covered Person recovers from anyone liable for the Covered Loss, We will be reimbursed first from such recovery to the extent of Our payments to the Covered Person. The Covered Person agrees to assist Us in preserving Our rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by Us.

ADMINISTRATIVE PROVISIONS

Cancellation
We or the **Participating Member** may cancel this **Certificate**, after the first year, as of any Premium Due Date by giving the other party 31 advance written or authorized electronic notice. Any premium rate guarantee will not affect Our or the Policyholder's right to cancel this Policy.

If We cancel this **Certificate**, any earned premium will be computed pro rata and any unearned portion promptly returned to the Participating Member. If the Policyholder cancels this Policy, any unearned premium paid to Us will be returned to the Participating Member immediately; or the Participating Member will immediately pay any earned premium to Us that has not been paid. Earned premium will be computed pro rata.

If a premium is not paid when due, We will cancel this **Certificate** at the end of the last period for which premium was paid, subject to the Grace Period provision. Cancellation does not affect a claim for a Covered Loss when the covered Accident or Sickness occurs before the cancellation date.

Grace Period
A Policy Grace Period of 31 days will be granted for payment of required premiums due after the first premium, unless:
1. We do not intend to renew this **Certificate** beyond the period for which premium has been accepted; and
2. Written notice of Our intention not to renew is delivered at least 45 days before the premium is due.

This Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, benefits will end on the last day of the Grace Period. The Participating Member is liable to Us for any unpaid premium for the time this Policy was in force.

Premiums
The Company provides benefits in return for premium payments. Premiums due for this Policy will be remitted to Us by the Policyholder or by any other person designated by the Policyholder to remit such premiums. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Premium Rate Changes
We may charge premium rates that vary by Participant Member. We may change premium rates at the end of any Policy Term or any Premium Rate Guarantee Period for any Participant Member with at least 31 days advance notice mailed to the last known address of the Policyholder. We will not increase premium rates more frequently than annually, unless one of the events described below occurs.

We may change the premium rate during a Policy Term or during any applicable Premium Rate Guarantee Period if any one of the following occurs:

1. the terms of this Policy change;
2. the number of Covered Persons or persons eligible for coverage increases or decreases by more than 10% since the later of the Policy Effective Date and the date of the last renewal of this Policy;
3. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of Covered Persons;
4. the ratio of incurred claims to earned premiums since the later of the Policy Effective Date and the last renewal date exceeds the permissible loss ratio;
5. the Participating Member fails to provide sufficient information, as required by Us, to confirm adequacy of premiums and rates currently being paid;

Any increase or decrease in rate will take effect on the date of the applicable change specified above, subject to required notification. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit
We will have the right to audit books and records of the Participating Member at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

Reinstatement
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 31 days prior to the date of reinstatement.

GENERAL PROVISIONS

Entire Contract; Changes
This Policy, **the Certificate**, including the endorsements, amendments and any attached papers constitutes the entire contract of benefits. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

If an enrollment form of any Covered Person is required, it may also be made a part of this Policy at Our option.

Addition of New Covered Persons
All Covered Persons added to one of the Classes under Eligible Persons in the Schedule of Benefits are eligible for benefits under this Policy, in accordance with its Effective Date provisions.

Misstatement of Fact
If the Participating Member or Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Assignment
No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment. These benefits may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Incontestability
1. Of This Policy

All statements made by the Participating Member to obtain this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Participating Member.

After one year from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of the Covered Person's benefits

All statements made by the Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After one year from the Covered Person's effective date of benefits, or from the effective date of increased benefits, no such statement will cause benefits or the increased benefits to be contested except for fraud or lack of eligibility for benefits.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Reporting Requirements

The Participating Member or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all Covered Person's insured on the **Certificate** Effective Date;
2. the names of all Covered Person's who are insured after the Certificate Effective Date;
3. the names of those persons whose benefits have terminated;
4. additional information required by Us.

We, at Our option, may waive reporting of any information specified above.

Mistake in Age

If the Age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at Our discretion, the amount of benefits payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same Age and similar circumstances.

Clerical Error

A Covered Person's coverage validly in force will not be affected, nor will a Covered Person's coverage validly terminated be continued, due to error or delay in keeping records pertaining to benefits under this Policy. If such error or delay is found, We will adjust the premium fairly.

Records

The Participating Member or its authorized administrator will maintain the records of the Covered Person's benefits under this Policy. We will be permitted to examine the Participating Member's records relating to the benefits under this Policy at any reasonable time. The Participating Member is acting as an agent of the Covered Person for transactions relating to this Policy. The actions of the Participating Member will not be considered Our actions.

Sanctions: In accordance with the U.S. Department of the Treasury's Office of Foreign Assets Control ("OFAC"), United Nations Security Council (UN), European Union (EU) and any other regulations, or any other applicable trade sanctions, embargoes or export controls applied by any regulatory body, if any insured, or any person or entity claiming the benefits of this insurance has violated U.S., UN, or EU sanctions, embargoes or export controls law, is a Specially Designated National and Blocked Person ("SDN"), or is owned or controlled by an SDN, this insurance will be considered a blocked or frozen contract. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC or the applicable regulator.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

Applicable Law, Legal Jurisdiction and Arbitration: The rights and obligations derived from this contract are governed by the laws of the Cayman Islands, B.W.I. This contract is made in the Cayman Islands with respect to payment of premiums and benefits, as well as to subsequently agreed amendments, agreements, modifications and endorsements thereto, as well as the issuance of this insurance policy and all related instruments.

Since the rights and obligations of this contract exist exclusively under the laws of the Cayman Islands, B.W.I., and are of local nature, the Company and the Insured, who by means of this document also obligates his or her beneficiaries, successors, assignees, as well as other third parties who may have a right or obligation therefrom, acknowledge that only the courts of the Cayman Islands, B.W.I. shall have jurisdiction and are capable of receiving and deciding upon any legal action with respect to the application, interpretation and validity of the arbitration clause as described in this section, and any other legal action that may result from this contract or the actions of the parties that may have an impact upon the obligations acquired and the rights derived from the existence of this contract that are not adjudicated, for any reason whatsoever, by the arbitration clause.

Any dispute that may arise between Pan-American International Insurance Corporation, the Insured and/or a beneficiary of the Insured, related to this contract or to its parts and its purpose, shall be resolved exclusively by private arbitration. Arbitration is mandatory, confidential and final. Each arbitration shall take place in the City of George Town, Grand Cayman, B.W.I., and the governing procedure shall be formulated and approved by the United Nations Commission on International Trade Law (UNCITRAL), on the effective date of this Certificate.

All notifications related to the arbitration proceedings shall be provided by international courier service, at the last known address of the parties. The arbitration shall be conducted in the English language. The decision shall be based in accordance with the ex aequo et bono principle and the customs and practices of the insurance industry, taking into account the agreements and understandings between the parties.

The court shall consist of three arbiters. Each party shall name an arbiter and the two arbiters thus named shall designate the third one. In each case, the arbiter must have at least five years' experience in the field of insurance and have no business connection with any of the parties.

Each party shall be responsible for its own expenses and costs and shall share the expenses and costs of the arbiters and of the arbitration in equal parts with the other party.

Important Information You Should Know
Privacy Practices

Respecting your privacy is a priority for Pan-American International Insurance Corporation (PAIIC). We take pride in keeping your personal information regarding insurance products and services you have with us private and confidential to assure we meet your financial needs.

To meet these objectives, we will collect, use and disclose your personal information only for purposes that include: underwriting, administration, claims adjudication, protecting against fraud, errors or misrepresentations, meeting legal, regulatory or contractual requirements. The only people who have access to your personal information are our employees, business partners such as insurance agents and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize.

This Notice has been provided to you in connection with a Certificate of Coverage or other materials which describes the benefits available to you under a student medical expense policy issued to the SMIC Trust. We will consider your utilization of coverage under the policy as evidence of your consent to Our processing of your sensitive information for the limited purpose of administering the coverage.

This notice serves as a summary of our privacy practices, and serves to briefly notify you of the information we collect about you, how we use it, how we protect it, and your rights.

For more information on our privacy practices, please visit www.palig.com/privacy-policy.
Information Collection, Protection, and Sharing

- We collect personal information in connection with the services offered. This may include information we receive on applications and other forms, contact information, medical and financial information, and information we receive from third-parties, including consumer reporting services.
- We process your personal information when necessary to provide the services set out in a contract, when it is in our or a third-party's legitimate interests, or when it is required or allowed by applicable law. When we process your sensitive personal data, it will be in line with applicable law, as necessary to provide you with our services, or with your permission.
- We share your information as necessary within our Group, with relevant policyholders, and with our business partners who help us provide services to you. We will only share your information as allowed under applicable law.
- We may disclose certain information to your insurance agent for the purpose of servicing your policy. However, you can limit or withdraw consent to these types of disclosures at any time.

  Pan-American Life is a global company, and where necessary we may allow your information to be shared with our affiliates or third-party service providers based in the United States and other countries. We will take steps to make sure that appropriate protection is in place to protect your information when it is transferred internationally.
- We keep your personal information in line with appropriate retention periods. The length of these periods is determined by relevant regulations, the information collected, and our obligations to you as a customer.
- Protecting your information is of the utmost importance to us. We use technical and physical safeguards to protect the security of your personal information from unauthorized disclosure. We also take every

step to ensure that only authorized employees and third-parties with legitimate business purposes have access to your personal information.

Your Rights

- You have the right to access your information and request corrections to your data.
- You also have the right to object to our use of your information, to request the transfer of information you have provided, to withdraw permission for our use of your information, and to ask us not to use automated decision-making which will affect you.
- Rights are not absolute and may be subject to review.

If you have any questions or concerns about this notice or Pan-American Life's privacy practices, you can contact us via email at privacy@palig.com or by telephone at 1-877-939- 4550.

In addition, the Office of the Ombudsman provides oversight on data protection matters: Office of the

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