2018 - 2019

STUDENT ACCIDENT ONLY INSURANCE PLAN

FOR THE STUDENTS OF SOUTHERN TECHNICAL COLLEGE

CL-107

Underwritten by:
Aegis Security Insurance Company

2407 Park Drive
Harrisburg, Pennsylvania 17106

LMITED ACCIDENT ONLY POLICY
NON-PARTICIPATING

BA2004-BROCHURE-FL College Coverage 06/2012

Policy Term

The insurance is effective 12:01 a.m. on August 01, 2018. An eligible Student's coverage becomes effective on that date or the date the application and full premium are received by the Company or Plan Administrator, whichever is later. The Policy terminates at 12:01 a.m. on October 31, 2019 or if earlier at the end of the period through which the premium is paid.

Eligibility

All Students of the Policyholder enrolled for a minimum of one credit hour and actively attending class on campus are eligible for the Accident Medical Expense Benefits described in this brochure. This coverage is in effect for Students 24-hours a day. If you wish to purchase these benefits, please complete and return the enrollment form found at the back of this brochure to Insurance For Students, Inc. no later than the first day of the session for which you are enrolling. The cost of insurance is $120.00 annually; $40.00 quarterly (3 months); $60.00 semester (4 months).

Identification Cards

The Student Identification Card can be obtained from Insurance For Students, Inc.

Refund of Premium

In the event the insured Student withdraws from school within the first 30 days of the semester, we will refund any premiums paid for the Student.
A pro-rata refund of premium will be made only in the event:

1. The Covered Student enters full-time active duty in any Armed Forces; and
2. We receive proof of such active duty service.

The Policy is issued in the state of Florida and shall be governed by its laws.

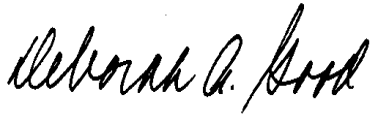
The Policy contains the terms under which We agree to insure Eligible Persons and pay benefits in return for the payment of premium.

Effective Date and Policy Term: The Policy takes effect on the Policy Effective Date. The period of insurance begins and ends at 12:01 A.M. Standard Time at the Policyholder's address.

We have issued the Policy in consideration of the Application signed by the Policyholder and payment of the required premium. We and the Policyholder have agreed to all the terms of the Policy.

Signed by:

President



Corporate Secretary

THIS IS A LIMITED ACCIDENT ONLY POLICY

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.
BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS IS A SINGLE TERM POLICY AND IS NOT RENEWABLE.

READ IT CAREFULLY.

To make an inquiry, obtain information about your coverage or to resolve a complaint call 1-800-356-1235

THIS POLICY CONTAINS A DEDUCTIBLE

EXCESS INSURANCE

ENROLLMENT INFORMATION

FOR QUESTIONS ON ENROLLMENT PLEASE CONTACT

INSURANCE FOR STUDENTS, INC
1690 S. CONGRESS AVE, SUITE 101 DELRAY BEACH, FL 33445
954-771-5883 ** 800-356-1235
FAX 954-772-0872

WEB SITE: WWW.INSURANCEFORSTUDENTS.COM

CLAIMS INFORMATION

FOR QUESTIONS ON CLAIMS PLEASE CONTACT

AEGIS GROUP
PO BOX 61140 HARRISBURG, PA 17106-1140
717-540-0600 ** 800-692-7338
FAX 717-657-9499
amersentq@aegisfirst.com

CLAIM PROCEDURE

In the event of an Injury, the Student should:

1. Obtain a claim form from Insurance For Students, Inc. or American Sentinel Insurance Company (ASIC).
2. Complete the claim form in full and sign it. The completed claim form should be mailed within 90 days from the date of Injury or as soon as reasonably possible. Retain a copy of the claim form for your records.
3. Itemized medical bills should be attached to the claim form at the time of submission. Subsequent medical bills should be mailed promptly to ASIC. No additional claim forms are needed as long as the Student's name and identification number are on the bill.
4. Direct all questions regarding claim procedures, status or payment of a claim to ASIC.

Claim Administrator for claims: American Sentinel Insurance Company, PO Box 61140, Harrisburg, PA 17106
phone 1-800-692-7338 ** fax 717-657-9499
amersentq@aegisfirst.com

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Section 1. DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the Policy. Additional terms may be defined within the provision to which they apply.

"Accident" means a sudden, unforeseeable event, definite as to time and place, from which:

(1) Injury occurs to one or more Covered Persons; and
(2) loss occurs while coverage is in effect for the Covered Person.

"Benefit Period" means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

"Covered Person" means a person eligible for insurance hereunder according to the eligibility and/or affiliation rules of the Policyholder, as set out in the Policy, for whom application has been accepted and proper premium payment has been made, and who is therefore insured under the Policy.

"Deductible" means the amount of Eligible Expenses which must be paid by the Covered Person before benefits are payable under the Policy. It applies separately to each Covered Person. The deductible is stated on the Schedule of Benefits.

"Doctor" means a licensed practitioner of the healing arts acting within the scope of his license, including a chiropractor.

"Eligible Expenses" means the Usual and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of Injury. Eligible Expenses must be incurred within the Benefit Period of the Policy.

"Emergency Medical Condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity,

- Information from consumer reporting agencies, public records, and data collection agencies, such as your obligations with others and your creditworthiness;

- Information you provide to us on applications or from health care providers, such as doctors and hospitals, to determine your past or present health condition. Health information will be collected as we deem appropriate to determine eligibility for coverage, to process claims, to prevent fraud, and as authorized by you, or as otherwise permitted or required by law.

How We Use Information About You

We use customer information to underwrite your policies, process your claims, ensure proper billing, service your account, and offer you other Aegis insurance products that we believe may suit your needs.

Information Disclosure

The Aegis Group may disclose all of the nonpublic personal information described above, as permitted by law. For example, we may use affiliated and nonaffiliated parties to perform services for us, such as providing customer assistance, handling claims, protecting against fraud, and maintaining software for us. We may also disclose information in response to requests from law enforcement agencies or State Insurance authorities.

We do not sell lists of our customers, nor do we disclose customer information to marketing companies outside The Aegis Group of companies.

Information Regarding Former Customers

The Aegis Group does not disclose nonpublic personal information about former customers or customers with inactive accounts, except in accordance with this Privacy Policy.

Changes To This Privacy Policy

We reserve the right to modify or supplement this Privacy Policy at any time. If we make material changes, we will provide current customers with a revised notice that describes our new practices.

The Aegis Group Protects Customer Information

We maintain physical, electronic, and organizational safeguards to protect customer information. We continually review our policies and practices, monitor our computer networks, and test the strength of our security in order to help us ensure the safety of customer information.

Notice of Privacy Policy

The trust of our customers is The Aegis Group's most valuable asset. The Aegis Group safeguards that trust by keeping nonpublic personal information about customers in a secure environment and using that information in accordance with this Privacy Policy. We value you as a customer and take your personal privacy seriously. We will inform you of our policies for collecting, using, securing, and sharing nonpublic personal information ("customer information") the first time we do business and every year that you are an Aegis customer.

This Privacy Policy includes examples of the types of nonpublic personal information we collect and the kinds of companies with whom we share such information. These examples are illustrative and should not be considered a complete inventory of our information collection, use, and sharing practices. In addition, you may have other privacy protections under some state laws. We will comply with applicable state laws regarding information about you. For example, certain state laws may restrict the types of information we may disclose about you or require us to provide you with additional notices.

Please note that this Privacy Policy will not apply to your relationships with other financial service providers, such as banks, credit card issuers, finance companies, and independent insurance agents that are not a part of The Aegis Group companies listed at the end of the Privacy Policy.

Their privacy policies will govern how they collect, use, and disclose personal information that you allow them to access.
Below is The Aegis Group's privacy pledge to our customers:

Information We May Collect

The Aegis Group may collect nonpublic personal information about you from the following sources:

- Information we receive from you (or is provided to us on your behalf) on applications and other forms, such as your name, address, telephone number, employer, and income. This includes information received through telephone or in-person interviews, your Aegis agent, and/or our Customer Service representatives;

- Information about your transactions with the companies of The Aegis Group or other nonaffiliated parties, such as your name, address, telephone number, age, credit card usage, insurance coverage, transaction history, claims history, and premiums;

including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

"He", "His" and "Him" includes "She", "Her" and "Hers".

"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

(1) group or blanket insurance, whether on an insured or self-funded basis;
(2) hospital or medical service organizations on a group basis;
(3) Health Maintenance Organizations on a group basis;
(4) group labor management plans;
(5) employee benefit organization plan;
(6) professional association plans on a group basis;
(7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
(8) automobile no-fault coverage.

"Hospital" means an institution which:

(1) is operated pursuant to law;
(2) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
(3) is under the supervision of a staff of Doctors;
(4) provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
(5) has medical diagnostic and treatment facilities, with surgical facilities;
    (a) on its premises; or
    (b) available to it on a prearranged basis; and
(6) charges for its services.

Hospital does not include:

(1) a clinic or facility for:
  (a) convalescent, custodial, educational or nursing care;
  (b) the aged, drug addicts or alcoholics;
  (c) rehabilitation; or
(2) a military or Veterans Hospital or a hospital contracted for or operated by a national government or its agency unless:
  (a) the services are rendered on an emergency basis; and
  (b) a legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital also includes a licensed emergency treatment center. The center must have permanent facilities and:

(1) a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) present at all times;
(2) an M.D. specialist representing each of the major specialties available within minutes;
(3) ancillary services, including laboratory and X-ray, staffed at all times; and
(4) a pharmacy staffed, or on call, at all times.

Hospital also includes a licensed hospital primarily of a rehabilitative nature, regardless of whether it has surgical facilities or not, if such rehabilitation is specifically for treatment of physical disability.

With respect to outpatient surgery or diagnostic testing, an ambulatory surgical center or a clinic will be considered as a Hospital. Such

facility must be properly accredited and, where required by law, hold a license allowing the facility to operate as such.

"Hospital Stay" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

"Injury" means bodily harm which results, directly and independently of all other causes, from an Accident. All injuries sustained in one

rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive an Accounting of Disclosures
You have the right to receive an accounting of all disclosures of your PHI that the plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by the plan after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive a Paper Copy of this Notice
You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed in this Notice.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the plan or the Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Contact listed in this Notice. The plan will not retaliate against you for filing a complaint.

PRIVACY CONTACT
You may contact the Privacy Officer for the plan at:

PO Box 61140
Harrisburg, PA 17106-1140
1-800-692-7338

EFFECTIVE DATE OF NOTICE
This notice published and becomes effective on April 14, 2003.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures
You have the right to request that the plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed in this Notice and must state the specific restriction requested and to whom that restriction would apply.

The plan is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications
You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed in this Notice.

Right to Access to Your Protected Health Information
You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the plan maintains the PHI. A designated record set contains claim information, premium and billing records and any other records the plan has created in making claim and coverage decisions relating to you. Federal law does prohibit you from having access to the following records: psychotherapy notes; information compiled reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Amend Protected Health Information
You have the right to request that PHI in a designated record set be amended for as long as the plan maintains the PHI. The plan may deny your request for amendment if it determines that the PHI was not created by the plan, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the plan has a right to include a

Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

"Intoxicated" means a blood alcohol level which equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred.

"Loss Period" means the period of time, as stated on the Schedule of Benefits, between the date of occurrence and the date within which the first Eligible Expense must be incurred.

"Medically Necessary" or "Medical Necessity" means the services or supplies provided by a Hospital, Doctor, or other covered provider that are required to identify or treat a covered loss and which, as determined by Us, are:

(1) consistent with the diagnosis and treatment of the covered loss;
(2) appropriate with the standards of good medical practice;
(3) not solely for the convenience of a Covered Person;
(4) the most appropriate supply or level of service which can be safely provided; and
(5) not considered experimental or investigative.

"Nurse" means a professional, licensed, graduate registered nurse (R.N.), a professional, licensed practical nurse (L.P.N.) or a Certified Registered Nurse Anesthetist C.R.N.A.).

"Orthopedic Appliances" means braces and appliances including durable medical equipment that:

(1) is primarily and customarily used to serve a medical purpose, can withstand repeated use; and
(2) generally is not useful to the person in the absence of a medical condition.

"Supervised and Sponsored Activity" means a Policyholder authorized function:

(1) in which the Covered Person participates;
(2) which is organized by or under its auspices; and
(3) which is within the scope of customary activities for such entity.

"Totally Disabled" means the Covered Person's inability to perform the substantial and material duties of their occupation or employment or, if a minor, the inability to engage in most normal activities of a person of like age and sex in good health. The inability must be as a result of Injury.

"Usual and Customary" means the fee regularly charged and received for a given service by a health care provider when furnishing customary treatment for a similar condition or Injury as represented by the 70th percentile of the Ingenix MDR database. We shall provide to a Covered Person, upon his written request, an estimate of the amount We will pay for a particular procedure or service. However, We will not be bound by such good faith estimate.

Example of How Claims are Paid Using "Usual and Customary" Charges:
A Covered Person submits a $310 claim to Us for covered medical expenses incurred for treatment of an Injury sustained in a covered Accident. We then input the treatment codes supplied by the provider, along with the provider's zip code, into the Ingenix MDR database and find that the 70th percentile is determined to be $300. We then process the claim using $300 as the "Usual and Customary" charge.

"We, Our, or Us" means the Aegis Security Insurance Company.

carriers; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the plan.
- Health-Care Operations. Health Care Operations refers to the basic business functions necessary to operate a health plan. Examples of uses and disclosures under this section include conducting quality assessment studies to evaluate the plan's performance or the performance of a particular network or vendor; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the plan; the disclosure of PHI to stop loss or reinsurance carriers to obtain claim reimbursements to the plan; disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to the plan; and use of PHI in general data analysis used in the long-term management and planning for the plan and company.

Other Uses and Disclosures Allowed Without Authorization
Federal law also allows a health plan to use and disclose PHI, without your consent or authorization, in the following ways:

- To you, as the covered individual.
- To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual.
- To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- To a Business Associate as part of a contracted agreement to perform services for the health plan.
- To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the Insurance Commissioner's Office, to respond to inquiries or investigations of the plan, requests to audit the plan, or to obtain necessary licenses.
- In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. For example to notify authorities of a criminal act.
- As required to comply with Workers' Compensation or other similar programs established by law.
- To the Plan Sponsor, as necessary to carry out administrative functions of the plan such as evaluating renewal quotes for reinsurance of the plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the plan.
- In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific condition that the plan is case managing.

The examples of permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

AEGIS SECURITY INSURANCE COMPANY
AMERICAN SENTINEL INSURANCE COMPANY
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER.

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how we may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a health plan we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices.

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the plan at that time.

PERMITTED USES AND DISCLOSURES

Treatment, Payment and Health Care Operations
Federal law allows a health plan to use and disclose PHI, for the purposes of treatment, payment and health care operations, without your consent or authorization. Examples of the uses and disclosures that we, as a health plan, may make under each section are listed below:

- Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a health plan we do not provide treatment.
- Payment. Payment refers to the activities of a health plan in collecting premiums and paying claims under the plan for health care services you receive. Examples of uses and disclosures under this section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine coordination of benefits or settle subrogation claims; providing PHI to the plan's UR Company for pre- certification or case management services; providing PHI in the billing, collection and payment of premiums and fees to plan vendors such as PPO Networks, UR Companies, Prescription Drug Card Companies and reinsurance

Section 2. SCOPE OF COVERAGE

We will provide the benefits described in the Policy to all Covered Persons who suffer a covered loss which:

(1) results, directly and independently of all other causes, from bodily Injury which is suffered in an Accident; and
(2) occurs while the person is a Covered Person under the Policy; and
(3) is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

Full Excess Medical Expense

If a Covered Person incurs Eligible Expenses for Covered Services, We will pay the applicable benefit for the expenses incurred, subject to the Deductible Amount, Benefit Percentage and Benefit Period shown on the Schedule of Benefits, that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The first expense must be incurred within the Loss Period stated on the Schedule of Benefits.

The Maximum Benefit Amount payable and sub-limits under the Policy are shown on the Schedule of Benefits.

Section 3. PROVISIONS CONCERNING COVERED PERSONS

Eligibility:

Persons eligible to be insured under the Policy are those persons described in the Schedule of Benefits. This includes anyone who becomes eligible while the Policy is in force.

Effective Dates:

An Eligible Person will become a Covered Person under the Policy, provided proper premium payment is made, on the latest of:

(1) the Policy Effective Date; or
(2) the day He becomes eligible.

Termination:

Insurance for a Covered Person will end on the earliest of:

(1) the date He is no longer an Eligible Person;
(2) full time active duty in any Armed Forces. (Send Us proof of service. We will refund any premium paid for this time.) This does not include Reserve or National Guard duty for training unless it extends beyond 31 days;
(3) the end of the period for which the last premium contribution is paid; or
(4) the date the Policy is terminated.

Termination will not effect a claim for a covered loss due to an Accident which occurred while coverage was in effect.

Extension of Benefits:

If a Covered Person is Totally Disabled when insurance under the Policy ends, We will provide for the continuation of the same Policy benefits in connection with the treatment of a covered loss incurred while the Policy was in effect. Such benefits will only be extended to the earlier of 90 days from the date the coverage ends; the date the maximum amount of benefits have been paid; or the end of the Total Disability.

Section 4. DESCRIPTION OF HAZARDS

SEE COLLEGE ACCIDENT-ONLY COVERAGE RIDER

calcium, direct, indirect and total bilirubin, total protein, albumin, globulin, anion gap, and magnesium;
(e) Up to 30 days of anti-HIV and anti-nausea medications when medically necessary;
(f) Follow-up physician or nurse evaluation, if on medication, at one, two and three weeks after anti-HIV medication is started when medically necessary; and
(g) Qualitative hepatitis C RNA serum polymerase chain reaction testing at two weeks if the source patient has evidence of having been infected with hepatitis C.

We do not pay for expenses for blood borne pathogen exposures occurring to an employee.

Any needed follow-up evaluation or treatment more than 30 days after the blood borne pathogen exposure is not covered.

COLLEGE ACCIDENT-ONLY COVERAGE RIDER

Section 4. DESCRIPTION OF HAZARDS

COLLEGE COVERAGE

Subject to all other provisions of the Policy, 24-hour coverage is provided for a Covered Person while enrolled at the Policyholder for a minimum of one credit hour.

Coverage is provided for the Benefits contained in Section 9 - Schedule of Benefits of the Policy as well as the Blood Borne Pathogen Exposure Expense Benefit added below.

Refund of Premium: In the event the Covered Person withdraws from the Policyholder within the first 30 days of the semester, We will refund any premiums paid for him or her.

Section 5. DESCRIPTION OF BENEFITS

BLOOD BORNE PATHOGEN EXPOSURE EXPENSE BENEFIT

We will pay 100% of the Usual and Customary charges incurred if: (a) a Covered Person, while enrolled in the Policyholder, is possibly or actually exposed to a blood-borne pathogen, via percutaneous, mucous membrane exposure; and (b) incurs charges listed below for testing and treatment within 30 days after such exposure.

Covered Services will include:

(a) An initial physician or nurse evaluation and treatment;
(b) Initial blood tests for HBsAG, HBsAb, HBcab, HCVAB, and HIV;
(c) The following whole blood tests if done with an automated cell counter: white blood cell count, red blood cell count, whole blood hemoglobin, hematocrit, platelet count, and differential blood count;
(d) The following serum tests when done with an automated analyzer: glucose, blood urea nitrogen, uric acid, creatinine, sodium, potassium, chloride, carbon dioxide, cholesterol, GGT, AGOT, AGPT, LDS, phosphorous , alkaline phosphatase,

Section 5. DESCRIPTION OF BENEFITS

MEDICAL EXPENSE BENEFIT

If the first Eligible Expense is incurred within the Loss Period, We will pay up to the Maximum Benefit Amount, subject to the Deductible Amount, as shown on the Schedule of Benefits, for the following Covered Services when Medically Necessary:

(1) Hospital room and board charges, up to the most common semi-private daily room rate, for each day of the Hospital Stay.
(2) Intensive care room and board charges. This payment is in lieu of payment for Hospital room and board charges for those days.
(3) Hospital miscellaneous charges, during a Hospital Stay. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.
(4) Outpatient charges, by a Hospital for:
    (a) pre-admission testing (confinement must occur within 7 days of the testing); or
    (b) emergency room treatment.
(5) Charges for the treatment of Emergency Medical Conditions.
(6) Surgical charges for:
    (a) a Doctor, for primary performance of a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. However, We will pay up to 1.50 times the Surgical procedure charge when more than one surgical procedure through different operating fields are performed during the same surgical session.
    (b) a Doctor, for assistant surgeon duties, a second surgical opinion, or consultation.
    (c) anesthesia and its administration.
    (d) use of surgical facilities.
(7) Charges by a Doctor for other than pre- or post-operative care:
    (a) for in-Hospital visits; and

(b) for office visits.

(8) Charges for X-ray and laboratory tests.

(9) Charges for nursing services, other than routine Hospital care, by or under the supervision of a licensed graduate registered nurse.

(10) Charges for physiotherapy:
- (a) while Hospital confined; or
- (b) as an outpatient.

Physiotherapy includes:
- (i) heat treatment;
- (ii) diathermy;
- (iii) microtherm;
- (iv) ultrasonic;
- (v) adjustment;
- (vi) manipulation; (vii) chiropractic care;
- (viii) massage therapy; and
- (ix) acupuncture.

(11) Ambulance service to and from the Hospital.

(12) Rental charges for medical equipment for:
- (a) a wheelchair;
- (b) an iron lung;
- (c) Orthopedic Appliances; or
- (d) other medical equipment for which prior approval by Us has been given.

(13) Charges for medical services and supplies for:
- (a) oxygen and its administration;
- (b) blood and blood transfusions.

(14) Charges for dental treatment, for Injury to a tooth which was sound and natural at the time of Injury.

(15) Charges for up to 40 home health care visits not to exceed $1,000 in any continuous 12-month period. Each visit by a member of a home health care team shall be considered as one home health care visit. Four hours of home health aide service shall be considered as one home health care visit.

"Home health care" means the care and treatment of a Covered Person who is under the care of a Doctor but only if hospitalization or confinement in a nursing facility as defined in the Social Security Act, would

100% of Usual and Customary charges

Emergency Room Medical Expense	$250.00 per Injury
Ambulance Expense	$300.00 per Policy Year
Outpatient Prescription Drug Expense	$150.00 per Injury
Outpatient Facility Expense	$2,000.00 per Injury

Benefit Percentage	100% of Usual and Customary
Benefit Period	One Year

Deductible Amount Per Covered Person:

Per Occurrence	$50

PREMIUM:

Annually	$120.00
4-Months	$ 60.00
3-Months	$ 40.00

Section 9. SCHEDULE OF BENEFITS

ELIGIBILITY REQUIREMENTS:

An Eligible Person means: All students of the Policyholder enrolled for a minimum of one credit hour.

DESCRIPTION OF HAZARDS: College Coverage (Student Accident 24-hour-a day)

DESCRIPTION OF BENEFITS:

Medical Expense Benefit
Plan Type: Full Excess Medical Expense – Initial Amount $100
Loss Period 60 days
Maximum Benefit Amount Per Covered Person $10,000
Hospital Room and Board Expense $500.00 per day
Surgical Expense (Inpatient or Outpatient) $1,500.00 per Injury

Miscellaneous Hospital Expense $1,000.00 per Injury

a. Anesthesia (including supplies and services)
b. Operating, Treatment Rooms and Equipment
c. Diagnostic X-ray and Laboratory Tests
d. Lab Studies
e. Oxygen tent
f. Blood and Blood Services
g. Prescribed Drugs and Medicines
h. Medical and Surgical dressings, supplies, casts and splints
i. Intravenous injections and solutions
j. Physical and Occupational therapy
k. Other necessary and prescribed hospital expenses

In-Hospital Doctor's Fees and Medical Expense $75.00 first visit
$25.00 Subsequent visit(s)
(limit one visit per day)

Outpatient Doctor Visit Expense $75.00 first visit
$50.00 Subsequent visit(s)
(limit one visit per day)

Blood Borne Pathogen Exposure Expense Benefit

otherwise have been required if home health care was not provided, and the plan covering the home health service is established and approved in writing by such Doctor.

Home health care shall be provided by an agency licensed pursuant to Florida law and shall consist of one or more of the following:

(a) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).
(b) part-time or intermittent home health aide services which consist primarily of caring for the patient.
(c) physical, occupational or speech therapy if provided by the home health service or agency.
(d) medical supplies, drugs and medications prescribed by a Doctor, and laboratory services by or on behalf of a certified home health agency or licensed home care services agency to the extent such items would have been covered under the contract if the Covered Person had been hospitalized or confined in a skilled nursing facility as defined in the Social Security Act.

Treatment which is covered on an inpatient basis will also be covered outside the Hospital by health care providers on the same basis as for those covered in the Hospital.

Section 6. EXCLUSIONS

Benefits will not be paid for a loss due to:

(1) intentionally self-inflicted Injury, suicide while sane or insane or any attempt thereat;
(2) voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of the Covered Person's Doctor;
(3) committing or attempting to commit a felony;
(4) participation in a riot or insurrection;
(5) an act of declared or undeclared war (not including terrorism);
(6) active duty service in any Armed Forces of any country and, in such event, the pro-rata unearned premium will be returned upon proof of service. This does not include Reserve or National Guard active duty or training unless it extends beyond 31 days ;
(7) practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in the Policy;
(8) parachuting, except for self preservation;
(9) bungie jumping, flight in an ultralight aircraft, hang-gliding;
(10) sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning;
(11) services or treatment rendered by a Doctor, Nurse or any other person who is:
    (a) employed or retained by the Policyholder; or
    (b) is the Covered Person, His spouse, parent, child or sibling;
(12) flight in an aircraft, except as a fare-paying passenger;
(13) dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth;
(14) any loss for which benefits are paid under any Worker's Compensation Act;
(15) treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
(16) cosmetic surgery, except for reconstructive surgery due to a covered Injury;

No change in the Policy will be valid unless the change is approved in writing and signed by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

CONFORMITY WITH STATE LAW:

Any provision of the Policy which, on the Policy Effective Date, is in conflict with the law of the state in which the Policy is issued, is hereby amended to conform to the minimum requirements of such law.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Covered Person's insurance under the Policy.

EXAMINATION AND AUDIT:

We shall be permitted to examine and audit the Policyholder's records relating to coverage under the Policy at any reasonable time up to the later of:

1) the two year period after the expiration of the Policyholder's coverage; or
2) the final adjustment and settlement of all claims under the Policyholder's coverage.

NEW ENTRANTS

All new members in the classes eligible for insurance will be added to such class for which they are eligible.

sign papers and do whatever is necessary to transfer His rights to Us. We will exercise such rights on His behalf. The Covered Person further agrees to furnish Us with all relevant information and documents. In no case will we receive an amount greater than the total amounts of benefits We have paid for such Injury.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits We have paid to Him for Injuries:

1) received in a covered Accident; and
2) which are paid under:
   a) Worker's Compensation; or
   b) Occupational Disease Law; or
   c) any Employer's Liability Insurance.

Section 8. GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the Application of the Policyholder, endorsements, riders and attached papers constitute the entire contract between the parties. If an application of a Covered Person is required, such application, at Our option, may also be made a part of this contract.

All statements made by the Policyholder or a Covered Person are, in the absence of fraud, deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be used as a defense to a claim unless (1) it is contained in a written Application signed by the Policyholder or Covered Person, whomever made the statement; and (2) a copy of the Application has been furnished to such person or His beneficiary or representative.

No statement of the Policyholder, except a fraudulent statement, shall be used to void the Policy after it has been in force for 2 years from its effective date. After the insurance of a Covered Person has been in force for 2 years under the Policy, no statement of the Covered Person, except a fraudulent statement, will be used to void the Covered Person's insurance or to deny or reduce a claim for loss incurred after the 2 year period.

(17) charges which the Covered Person would not have to pay if He did not have insurance;
(18) eyeglasses, contact lenses, hearing aids; and
(19) charges which are in excess of Usual and Customary charges.

Section 7. CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice must be given to Us within 90 days after covered loss occurs or begins or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include the Policyholder's name, the Policy number and the Covered Person's name and address.

CLAIM FORMS:

When We or Our authorized representative receive the notice of claim, We will send forms for filing proof of loss. (Our authorized representative may have already supplied claim forms.) If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us at Our home office or to Our authorized representative within 90 days after the date of the loss or as soon as reasonably possible. Proof must, however, be furnished no later than twelve months from the time it is otherwise required, except in absence of legal capacity.

TIME OF PAYMENT OF CLAIMS:

Benefits for any loss covered by the Policy will be paid as soon as We receive proper proof.

We will reimburse all claims or any portion of any claim from the Covered Person or the Covered Person's assignee, for payment under the Policy, within 45 days after We receive the claim. If a claim or a portion of a claim is contested by Us, the Covered Person or the

Covered Person's assignee shall be notified, in writing, that the claim is contested or denied, within 45 days after We receive the claim. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. We, upon receipt of the additional information requested from the Covered Person or the Covered Person's assignee, will pay or deny the contested claim or portion of the contested claim within 60 days. We will pay or deny any claim no later than 120 days after We receive the claim.

Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment is placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments will bear simple interest at the rate of 10 percent per year.

Upon written notice by the Covered Person, We will investigate any claim of improper billing by a Doctor, Hospital or other health care provider. We will determine if the Covered Person was properly billed for only those procedures and services that the Covered Person actually received. If We determine that the Covered Person has been improperly billed, We will notify the Covered Person and the provider of our findings and We will reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notice by the Covered Person, We will pay to the Covered Person 20 percent of the amount of the reduction up to $500.

PAYMENT OF CLAIMS:

If the Covered Person dies, We will pay any accrued benefits at the time of death to the beneficiary or, if no beneficiary is designated and surviving the Covered Person, then as follows:
(1) the Covered Person's parents or legal guardian, if a minor;
(2) otherwise to the Covered Person's estate.

If any benefits are payable to the estate or to a person who is incapable of giving a valid release, We may pay up to $1,000 to any relative by blood or marriage whom We find entitled to the payment. This good faith payment satisfies Our legal duty to the extent of the payment.

All other benefits will be paid to the Covered Person. All or a portion of the benefits, if any, provided by the policy may be paid directly to

the Hospital, Doctor or person upon whose charges the claim is based. The Covered Person must make a written request to Us before We can do this. We must receive the request no later than the time for filing proof of loss.

Providers of covered ambulance services will be paid directly by Us if payment has not been received from any other source.

SELECTION AND CHANGE OF BENEFICIARY:

The Covered Person has the right to select or change the beneficiary at any time by giving Us written notice. The beneficiary's consent is not required for this or any other change which the Covered Person may make unless the designation of beneficiary is irrevocable.

INTOXICANTS AND CONTROLLED SUBSTANCES:

We will not be liable for any loss sustained or contracted in consequence of the Covered Person's being Intoxicated or under the influence of any controlled substance unless administered on the advice of a Doctor.

PHYSICAL EXAMINATION AND AUTOPSY:

We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at Our expense unless prohibited by law.

LEGAL ACTIONS:

No action at law or in equity shall be brought to recover benefits under the Policy less than 60 days after written proof of loss has been furnished as required by the Policy. No such action shall be brought after the expiration of the applicable statute of limitations.

SUBROGATION:
If We have paid benefits to a Covered Person for an Injury, and in Our opinion a third party may be liable, We will be subrogated to the extent of such payment and to all rights of the Covered Person regarding recovery of benefits paid or to any settlement or judgement which results from the exercise of these rights. The Covered Person agrees to