

HM LIFE INSURANCE COMPANY

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Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Northwestern University

CERTIFICATE OF COVERAGE

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. HM-2045-A-09 ("the Policy")

Participating Organization or Institution: Northwestern University

Participating Organization's or Institution's Effective Date: June 1, 2009

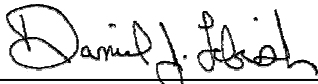
Eligible Participant: See Identification Card Issued to Participant

Eligible Dependents: See Identification Card Issued to Participant

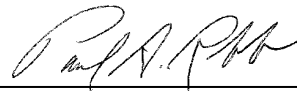
Coverage Start Date: See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a "Covered Person," and to **HM Life Insurance Company** as "Insurer." The Policy will be administered on behalf of the Insurer by the "Administrator," Worldwide Insurance Services, Inc., aka "HTH Worldwide".

This Certificate replaces all certificates previously issued to the Eligible Participant as evidence of coverage under the Policy.



President



Secretary

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**SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES**

The Classes eligible for coverages available under the Policy are shown below. The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.

- Class I: Study Abroad Student Eligible Participants enrolled in the educational institution's sponsored or approved study abroad program and their Eligible Dependents.
- Class II: Study Abroad Staff Eligible Participants providing direct support to the educational institution's sponsored or approved study abroad program at its Country of Assignment location and their Eligible Dependents.

All benefits and limits are stated per Covered Person

**SCHEDULE OF BENEFITS
TABLE 1**

	Limits Eligible Participant	Limits Spouse	Limits Child
COVERAGE A – MEDICAL EXPENSES			
Lifetime Maximum Benefit	\$1,000,000	\$1,000,000	\$1,000,000
Policy Year Maximum Benefits	\$250,000	\$250,000	\$250,000
Maximum Benefit per Injury or Sicknesses	\$250,000	\$250,000	\$250,000
Deductible	\$0 per Injury or Sickness	\$0 per Injury or Sickness	\$0 per Injury or Sickness
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to \$10,000	Maximum Benefit: Principal Sum up to \$5,000	Maximum Benefit: Principal Sum up to \$1,000

**SCHEDULE OF BENEFITS
TABLE 2**

COVERAGE A – MEDICAL EXPENSES	Indemnity Plan Limits
Physician Office Visits	100% of Reasonable Expenses
Inpatient Hospital Services	100% of Reasonable Expenses
Hospital and Physician Outpatient Services	100% of Reasonable Expenses

**SCHEDULE OF BENEFITS
TABLE 3
COVERAGE A – MEDICAL EXPENSE BENEFITS**

BENEFITS LISTED BELOW ARE SUBJECT TO

1. TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;
2. TABLE 2 PLAN TYPE LIMITS (INDEMNITY)

MEDICAL EXPENSES	COVERED PERSON
Maternity Care for a Covered Pregnancy	Reasonable Expenses. Conception must have occurred while the Covered Person was insured under the Policy.
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$5,000 Maximum per Lifetime for a maximum period of 30 days per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$1,000 Maximum per Lifetime
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to \$10,000 Maximum combined total for Inpatient and Outpatient care, up to 30 days immediately following the attending Physician's release for rehabilitation following a covered Hospital confinement or surgery per Policy Year
Therapeutic termination of pregnancy	Reasonable Expenses up to \$500 per Policy Year
Routine nursery care of a newborn child of a covered pregnancy	Reasonable Expenses up to \$500 per Policy Year
Medical treatment arising from participation in intercollegiate, interscholastic, intramural or club sports	Reasonable Expenses up to \$5,000 Maximum per Injury or Sickness
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$500 per Policy Year Maximum
Outpatient prescription drugs including oral contraceptives and devices	100% of Actual Charge
Professional ground or air ambulance service to nearest hospital	Reasonable Expense up to \$350 per Injury or Sickness

**SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES**

- A. What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit for the Eligible Participant or the Maximum Benefit for an Eligible Dependent stated in Coverage A – Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Co-payments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, and to all other limitations and provisions of the Policy.
- B. Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group policy administered by the Administrator immediately prior to the Policy Effective Date, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance.

1. **Physician office visits.**

2. **Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

If Tests and X-rays are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services there is no additional Copayment for these Tests or X-rays. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

C. **Additional Covered General Medical Expenses and Limitations:** These additional Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

1. **Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Conception must have occurred while the Covered Person was insured under the Policy. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
- a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
 - b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a) Parental education;
- b) Assistance and training in breast or bottle feeding; and
- c) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

2. **Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear. (Cervical screenings are not subject to the deductible provision). This benefit includes coverage for a human papillomavirus vaccine (HPV) that is approved for marketing by the federal Food and Drug Administration.

3. **Mammography screening, clinical breast exam when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:

Mammogram and Breast Exam

- 1) A baseline mammogram for women 35 to 39 years of age.
- 2) An annual mammogram for women 40 years of age or older.
- 3) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer,
- 4) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice.
- 5) Complete and thorough clinical breast examinations as indicated by guidelines of practice, performed by a physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating physician that authorizes breast examinations, or a physician assistant who has been delegated authority to provide breast examinations, to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:
 - a) at least every 3 years for women at least 20 years of age but less than 40 years of age;
 - b) annually for women 40 years of age or older.

4. **Shingles Vaccine:** We will provide coverage for a vaccine for shingles that is approved for marketing by the federal Food and Drug Administration if the vaccine is ordered by a physician licensed to practice medicine and the enrollee is 60 years of age or older.

SECTION 3
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

SECTION 4
LIMITATIONS

A. Pre-Existing Condition Limitation

The Insurer does not pay benefits for loss due to a Pre-Existing Condition.

B. Limitation of Maternity Coverage.

The Policy does not pay benefits for maternity coverage unless conception occurred while the Covered Person was insured under the Policy.

SECTION 5
GENERAL POLICY EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Expenses incurred in excess of Reasonable Expenses.
2. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, including routine care of a newborn infant.
3. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
5. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
6. Elective termination of pregnancy.
7. Expenses incurred as a result of pregnancy that is not covered.
8. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
9. Organ or tissue transplant.
10. Participating in an illegal occupation or committing or attempting to commit a felony.
11. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
12. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
13. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
14. Expenses incurred within the Covered Person's Home Country.
15. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.
16. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
17. Diagnosis and treatment of acne and sebaceous cyst.
18. Outpatient treatment for specified therapies including, but not limited to, Physiotherapy and acupuncture.

19. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
20. Self-inflicted Injuries while sane or insane; suicide, or any attempt thereof while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
21. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion.
22. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
23. Loss arising from
 - a. participating in any professional sport, contest or competition;
 - b. skin/scuba diving, sky diving, hang gliding, bungee jumping.
24. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
25. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
26. Services or supplies that the Insurer considers to be Experimental or Investigative.

SECTION 6 DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Age means the Covered Person's attained age.

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 Surgical Facility 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.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Reasonable Expenses for Medically Necessary treatment. The percentage the Insurer 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.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

Copayment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.

Country of Assignment means the country for which the Eligible Participant has a valid visa, if required, and in which he/she is undertaking an educational activity.

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, except as stated in the Extension of Benefits provision.

A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section 2.

Covered Person means an Eligible Participant and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person on a per Injury or per Sickness basis before certain benefits are payable under the Policy. The Deductible Amounts are stated in the Schedule of Benefits.

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.

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 26 who are chiefly dependent upon the Eligible Participant for support and maintenance, or becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. This insurance will continue for as long as the Covered Employee's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 26;

The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who

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

Eligible Participant means a person who:

1. Is engaged in international educational activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Emergency Hospitalization and Emergency Medical Care 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 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 sub acute 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.

Experimental or Investigative 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. The Insurer will make the final determination as to what is Experimental or Investigative.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the 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.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

Intensive Care Facility means an intensive care unit, 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.

Medically Necessary services or supplies are those that the Insurer determines 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 inpatient 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 outpatient or in a less intensified medical setting.

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

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Non-hospital Residential Facility means a facility certified by the District or by any state or territory of the United States as a qualified non-hospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. The term "non hospital residential facility" includes any facility operated by the District, any state or territory, or the United States, to provide these services in a residential setting.

Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician's office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Physiotherapy means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

Policy Year means the period beginning on the Participating Organization's or Institution's effective date. It includes the period beginning on the date a Covered Person's coverage under the Policy starts. It ends on the date the Covered Person's insurance under the Policy ends.

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received up to one (1) year prior to the Covered Person's effective date of coverage.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

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/her name.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Policy.

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.

2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
 - a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
 - b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

Written Request means a request on any form provided by the Administrator for particular information.

11:59:59 p.m. means 11:59:59 p.m. at the Covered Person's location.

12:00:01 a.m. means 12:00:01 Eastern Prevailing Time in Washington, DC.

SECTION 7 EXTENSION OF BENEFITS

If the Insurer terminates the Policy, coverage will be extended for a Covered Person who:

1. Is Totally Disabled on the date coverage ends; or
2. Is pregnant on the date coverage ends if the pregnancy manifested itself while insurance was in force under the Policy.

Coverage under this provision is provided only for Covered Medical Expenses with respect to:

1. A Totally Disabled Covered Person, for the condition causing the Total Disability; and
2. A pregnant Covered Person, for that pregnancy, childbirth or miscarriage.

Coverage so extended will end on the first of the following to occur:

1. The 90th day following termination of the Policy; or
2. The date the Total Disability ends; or
3. The end of the pregnancy; or
4. The end of the 52 week period during which expenses must be incurred to receive benefits under the Policy.

Except as stated above, coverage is not provided for any expense incurred after the date the Policy terminates.

This coverage extension will not apply to termination initiated by any Covered Person, Participating Organization or Institution or the Policyholder.

SECTION 8 EXCESS COVERAGE

The Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies.

SECTION 9 ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1—Eligible Classes. He/she must not be insured under the Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.

Enrollment for Coverage: An Eligible Participant will be eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date shown on the Insurance Identification Card, if any;
4. The date the requirements in Section 1 – Eligible Classes are met; or
5. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

For Transfers Only: If a Covered Person transfers from a Group which has coverage under a policy issued on the same form as this plan of insurance to another Group which also has coverage under the same policy form, or transfers from one plan to another under the same policy, and coverage is continuous, then coverage is continued between the two plans of insurance. A Covered Person will be covered under the newer plan for medical conditions which first arise on or after the transfer date. A Pre-Existing Condition will not be covered under the newer plan until the benefit

period expires for such condition under the prior plan (the plan under which the Covered Person was insured prior to the date of transfer). At that time, the Pre-Existing Condition will be covered under the newer plan. Benefit payments for Pre-Existing Conditions shall be the lesser of:

1. The unused portion of the maximum benefit applicable to the covered medical condition under the prior plan; or
2. The maximum benefit applicable to the covered medical condition under this plan.

Both 1 and 2 above are subject to the benefit periods, Deductibles, and Coinsurance as defined in the respective policies.

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
2. The Participating Organization's or Institution's Termination Date;
3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
4. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
5. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage or if the enrollment form contained inaccurate or misleading information.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

When an Eligible Dependent's Coverage Starts: 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, entry into or departure from the Country of Assignment. An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date of the Eligible Participant's insurance;
4. The effective date shown on the insurance identification card, if any;
5. The date the eligibility requirements in this section are met; or
6. The date the completed enrollment form, if any, and premium are received by the Insurer.

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

When an Eligible Dependent's Coverage Ends. An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates; or
2. The Participating Organization's or Institution's Termination Date;
3. The date the Eligible Participant is no longer covered under the Policy;
4. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;
5. 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her 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 dependent ceases to meet the eligibility requirements.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.

SECTION 10 COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits. "Expenses for Routine nursery care" of a newborn infant of a covered Pregnancy are covered up to the limits, if any, shown in the Schedule of Benefits.

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of placement for adoption, provided the Eligible Participant's coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement.

Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.

Expenses for routine nursery care means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.

In order to continue the coverage of a newborn child beyond the 31st day following his/her date of birth or of an adopted child beyond the 31st day following his/her placement:

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 31 days from the date of birth or placement.

SECTION 11 CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Policy which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to \$1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

All benefits payable under the Policy shall be payable to the Insured or to his/her designated beneficiary or beneficiaries, or to his/her estate. If the Insured is a minor, benefits may be payable to his/her parents, guardian, or other person actually supporting him/her, or to a person or persons upon whom such minor is chiefly dependent upon for support and maintenance.

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

SECTION 12 GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Participating Organization or Institution, copies of which are attached to and made a part of the Policy. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Policy has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Policy unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after 2 years from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Policy.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance 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 clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers' compensation. The Policy does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Policy in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

Grievance Procedures: If the Covered Person's claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

The Covered Person has the right to appeal any denial of a claim for benefits by submitting a written request for reconsideration with the Insurer. Requests for reconsideration must be filed within 60 days after receipt of the written notification of denial. When the Insurer receives the Covered Person's written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Covered Person's satisfaction, he/she may request a second review of the claim by sending the Insurer a written request for a second reconsideration. This written request must be filed within 60 days of the Eligible Participant's receipt of the Insurer's written notification of the result of the first review. If the issue involves a dispute over the coverage of medical services, or the extent of that coverage, the second review will be completed by physician consultants who did not take part in the initial reconsideration. The Covered Person will be informed, in writing, of the Insurer's final decision.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Eligible Participant or the Group because the Eligible Participant, the Group, or any person acting on the Eligible Participant's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

The Insurer will meet any Notice requirements by mailing the Notice to the Group at the billing address listed on our records. The Group will meet any Notice requirements by mailing the Notice to:

**HM Life Insurance Company
120 Fifth Avenue
Fifth Avenue Place
Pittsburgh, PA 15222**

Dispute Resolution

All complaints or disputes relating to coverage under this Plan must be resolved in accordance with the Insurer's grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by the Insurer that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Covered Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer propose to resolve the grievance.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Insured Participant and his/her Insured Dependents or the Group because the Insured Participant's, the Group's, or any person's action on the Covered Person's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

1-800-328-5433

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Student Blanket

Endorsement to Policy/Certificate State of Illinois

This Endorsement is made part of the policy/certificate to which it is attached as of the effective date of such policy/certificate.

By attachment of this Endorsement, it is understood and agreed that the insurance under the policy/certificate is amended, with respect to Covered Persons residing in the state of Illinois, as follows:

1. Under Section 6, Definitions, the entry for Accident (Accidental) is deleted in its entirety and is replaced with the following:

Accident (Accidental) means identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

2. Under Section 9, Definitions, the entry for Injury is deleted in its entirety and is replaced with the following

Injury means bodily injury caused directly by an Accident. It must be independent of disease or bodily infirmity. To be covered, the Injury must first be treated while the Covered Person is insured under the 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.

3. Under Section 5, General Policy Exclusions, Exclusions #21 are deleted in their entirety and is replaced with the following clauses:

21. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion

4. Under Section 8, the entry for Excess Coverage is deleted in its entirety and is replaced with the following clause:

EXCESS COVERAGE

If this policy is provided to you on a voluntary basis in which premiums are paid by the student, parent, or guardian, this policy will cover the first \$100 of eligible charges incurred. After the first \$100 in benefits has been paid, this Policy will continue to pay benefits if there is no Other Plan of coverage in effect. However, if there is an Other Plan of coverage, claims for benefits in excess of the first \$100 must be filed with the Other Plan of coverage until those benefits have been exhausted. Once Other Plan of coverage benefits is exhausted, this policy is then to provide coverage for eligible expenses up to the policy maximum benefit.

If this policy is provided to you as part of your enrollment in school, and 100% of the premiums are paid by the school, the Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies.

5. Under Section 11, Claim Provisions, the entry for Time Payment of Claims is deleted in its entirety and is replaced with the following clause:

Time Payment of Claims: Benefits for a loss covered under this Plan will be paid as soon as the Insurer receives proper written proof of such loss. Any benefits payable to the Eligible Participant and unpaid at the Eligible Participant's death will be paid to the Insured Person's estate. Failure to pay within 30 days following receipt by the insurer of due proof of loss shall entitle the insured to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

6. Under Section 12, General Provisions, the entry for Subrogation is deleted in its entirety and is replaced with the following clause:

Third Party Liability

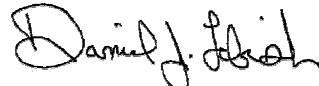
No benefits are payable for any Illness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Insurer will advance the benefits of this Plan to the Insured Person subject to the following:

1. The Insured Participant agrees to advise the Insurer, in writing, within 60 days of any Insured Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as the Insurer may require to facilitate enforcement of the claim. The Insured Participant and Insured Person also agree to take no action that may prejudice the Insurer's rights or interests under this Plan. Failure to provide notice of a claim or to cooperate with the Insurer, or actions that prejudice the Insurer's rights or interests, will be material breach of this Plan and will result in the Insured Participant being personally responsible for reimbursing the Insurer.
2. Right of Reimbursement: If an Insured Person incurs expenses for sickness or injury that occurred due to the negligence of a third party:
 - a. We have the right to reimbursement for all benefits we paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, covered person's parents, if the covered person is a minor, or covered person's legal representative as a result of that sickness or injury; and
 - b. We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury.

We shall have the right to first reimbursement out of all funds the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

THIS ENDORSEMENT IS SUBJECT TO ALL PROVISIONS OF THE POLICY/CERTIFICATE NOT INCONSISTENT HEREWITH.


President

- END OF CERTIFICATE -

HTH Worldwide Global Health and Safety Membership Program

Participating Organization or Institution:	Northwestern University
Participating Organization's or Institution's Effective Date:	June 1, 2009
Covered Member:	See Application Completed by Covered Member
Program Start Date:	See Application Completed by Covered Member

TERMS AND CONDITIONS

The following terms and conditions apply to the HTH Worldwide Global Health & Safety membership program (hereafter "the Program") provided by HTH Worldwide Insurance Services, Inc. (hereafter "HTH Worldwide"):

ELIGIBILITY

The following eligibility requirements apply to membership in this program:

1. Only those persons designated as Covered Members by the Participating Organization shall be eligible for services under this program.
2. Membership in the HTH Worldwide Global Health and Safety program continues only for the period for which the subscription fee has been paid.
2. Newborn or adopted children are covered under the Program for the first 31 days from the date of birth or adoption. Eligibility after that is subject to the newborn's or adopted child's inclusion on the Application and the Covered Member has paid the applicable subscription fee.

PAYMENT OF FEES AND REIMBURSEMENTS

1. All initial and supplemental Program fees are due and payable on or before the commencement date, unless HTH Worldwide has agreed to invoice the Participating Organization.
2. Any payments, guarantees or advances made by HTH Worldwide under the Program on behalf of a Covered Member that are not listed in the Service Program Limitation Schedule are made as agent for the Covered Member. HTH Worldwide may, at its discretion, require a deposit to be furnished by the Covered Member before such services are rendered.
3. The Member's obligation to pay Program fees and Reimbursements shall not be contingent on the outcome of any insurance or third party claim.
4. Membership fees are not refundable except before the commencement of the membership period.
5. Membership programs are not transferable.

Upon termination, HTH Worldwide and service providers engaged by HTH Worldwide shall continue to render services initiated before the termination date. The Covered Member shall pay for such services in accordance with costs and fees determined by HTH Worldwide.

DESCRIPTION OF SERVICES

Emergency Medical Evacuation: If a Covered Member is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services while traveling outside of their home country, and adequate medical facilities are not available, HTH Worldwide will coordinate and pay for a medically-supervised evacuation to the nearest appropriate medical facility. Said evacuation, which shall be performed under medical supervision, will be to the nearest medical facility capable of providing adequate care and will only be performed if such care is not available locally. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by HTH Worldwide after consultation with the attending physician on medical factors and their decisions shall be conclusive in determining the need for such services. As part of a medical evacuation, HTH Worldwide shall also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital. All evacuations must be approved and coordinated by HTH Worldwide-designated physicians. Transportation must be by the most direct and economical route.

When medically necessary and subject to the HTH Worldwide's prior approval, HTH Worldwide will pay for a medically supervised return to the Covered Member's permanent residence or, if appropriate, to a health care facility nearer to their permanent residence. Transportation shall not be considered medically necessary if the physician designated by HTH Worldwide determines that the Covered Member can continue his or her trip or can use the original transportation arrangements that he or she purchased.

Repatriation of Remains: If a Covered Member dies, while traveling outside of their home country, HTH Worldwide will pay the necessary expenses actually incurred, for the repatriation of the Covered Member's remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body or visitation or funeral expenses. Any expense for repatriation of remains requires HTH Worldwide's prior approval.

Bedside Visit: If a Covered Member is hospitalized for seven (7) or more consecutive days, is likely to be hospitalized for seven (7) or more days or is in critical condition, HTH Worldwide shall arrange and pay for the cost for one economy round-trip air fare ticket to the place of the Hospital Confinement, for one person designated by the Covered Member. Payment for hotels, meals, ground transportation and other incidentals are the responsibility of the family member or friend. The determination of whether the Covered Member will be hospitalized for seven (7) or more days or if the Covered Member is in critical condition shall be made by HTH Worldwide after consultation with the attending physician. No more than one (1) visit may be made during any 12 month period.

DEFINITIONS

Regional Medical Advisors are licensed physicians retained by HTH Worldwide

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Member is enrolled in the Program.

Application means all information provided by the Covered Member for the preparation and administration of the Program.

Country of Assignment means the country of permanent residence outside the Home Country as stated on the application.

Covered Member means an Eligible Participant and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 19 who are chiefly dependent upon the Eligible Participant 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 Eligible Participant during any waiting period prior to finalization of the child's adoption.

Eligible Participant means a person:

1. Who is a person validly enrolled in the Program;
2. Who meets the Eligibility Requirements as specified for the Program; and
3. For whom HTH Worldwide, or its agent, has received the appropriate Program fees.

Emergency Medical Services are urgent medical services and care rendered by a health care provider for the treatment of sudden accidental injuries sustained by a Covered Member or due to a sudden, unforeseen illness requiring immediate medical attention.

Emergency is a situation when, in the professional opinion the health care provider and HTH Worldwide, a clear and significant risk of death or imminent serious injury or harm to a Covered Member exists and for which evacuation is usually required in 24-48 hours.

Evacuation Decision: Medical considerations including the opinion of the treating physician, the Regional Physician Advisor and/or the Assistance Company, and the student's condition and ability to travel will determine the method and appropriate time of evacuation. All evacuations, transportations after initial evacuation, and repatriations of mortal remains are coordinated by and subject to the prior approval of HTH Worldwide and its Regional Medical Advisor and are paid directly by HTH Worldwide.

Enrollment Period means the period of time for which the Covered Member is validly enrolled for the Program and for whom HTH Worldwide has received the appropriate enrollment fee.

Home Country means the Covered Member's country of citizenship as stated on the Application. For purposes of providing medical evacuation and repatriation services: (1) The Covered Member's immediate family (spouse, dependent children, or life partner) shall be deemed to have the Covered Member's nationality; and (2) in the event of dual nationality, the Covered Member must elect one nationality.

Illness means a sudden and unexpected sickness that manifests itself during the Enrollment Period.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Member is insured under the Policy. An Illness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of an Illness is an Injury.

Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

Principle Country of Residence: The country in which the Covered Member has his/her permanent home, and as shown on the Member's passport.

Reimbursements means any and all payments due to HTH Worldwide, in addition to the initial or supplemental subscription fees, for payments, advances or guarantees made by HTH Worldwide on behalf of the Covered Member.

Serious Medical Condition means a condition which in the opinion of an HTH Worldwide physician requires emergency medical treatment to avoid death or serious impairment to the Covered Member's health. In determining whether a Serious Medical Condition exists, the HTH Worldwide physician may consider the Member's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

EXCEPTIONS

The following treatment, items, conditions, activities and their related or consequential expenses are excluded unless HTH Worldwide has given its prior written approval and the Member has paid the designated fees:

1. Hospital or medical expenses of any kind or nature.
2. More than one Emergency Medical Evacuation and/or repatriation for any single medical condition of a Covered Member during the term of the Program.
3. Any cost or expense not expressly covered by the Program and not approved in advance and in writing by HTH Worldwide and/or not arranged by HTH Worldwide. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when HTH Worldwide cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Covered Member.
4. Any event occurring when the Covered Member is within the territory of his/her Home Country or when the Covered Member is within 100 miles from the territory of his/her home in the Home Country or Country of Assignment.
5. Any expense for Covered Members, contrary to the advice of a medical practitioner, for the purpose of obtaining medical treatment or for rest and recuperation following any prior accident, illness or Pre-existing Condition.
6. Any expense for medical evacuation or repatriation if the Covered Member is not suffering from a Serious Medical Condition, and/or in the opinion of the HTH Worldwide physician, the Covered Member can be adequately treated locally, or treatment can be reasonably delayed until the Covered Member returns to his/her Home Country or Country of Assignment.
7. Any expense for medical evacuation or repatriation where the Covered Member, in the opinion of the HTH Worldwide physician, can travel as an ordinary passenger without a medical escort.
8. Any treatment or expense related to childbirth, miscarriage or pregnancy. This exception shall not apply to any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty-four (24) weeks of pregnancy.
10. Any expense related to the Covered Member engaging in any form of aerial flight except as a passenger on a scheduled airline flight; as a passenger on a licensed charter fixed wing aircraft over an established route; or as a passenger traveling on a business related activity in a fixed wing aircraft owned or leased to the Covered Member.
11. Any expense related to the Covered Member engaging in the commission of, or the attempt to commit, an unlawful act.
12. Any expense related to treatment performed or ordered by a non-registered practitioner not in accordance with the standard medical practice as defined in the country of treatment.
13. Any expense incurred as a result of the Covered Member engaging in active service in the armed forces or police of any nation; active participation in war (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, rebellion, riot, revolution or insurrection.
14. Services not otherwise shown as covered.

HTH Worldwide at its sole discretion will assist Covered Members on a fee-for-service basis for interventions falling under the above Exceptions. HTH Worldwide reserves the right, at its sole discretion, to request additional financial guarantees or indemnification from the Covered Member prior to rendering such services on a fee-for-service basis.

GENERAL PROVISIONS

Contract Documents

The Terms and Conditions and Application shall be deemed the Agreement and are incorporated herein by reference.

Indemnification, Limitations and Waivers

In the course of providing services under the Program, HTH Worldwide may be engaged in ultra-dangerous or hazardous circumstances, emergency situations, high-risk activities, sudden or unexpected events and occurrences. Given these unusual and difficult circumstances, it is agreed that:

Indemnification

The Covered Member agrees to indemnify, defend and hold HTH Worldwide, its subsidiaries and affiliates, and their respective directors, officers and employees, harmless from and against any and all claims, suits, actions, proceedings, or liabilities of any kind, including reasonable attorney's fees and expenses, arising out of its wrongful conduct, omission or the fault of its agents, employees or Covered Members.

Force Majeure

HTH Worldwide shall not be liable for failure to provide services and/or delays caused by acts of God, strikes, or conditions beyond its control, including but not limited to, flight conditions or situations where the rendering of services is prohibited or delayed by local laws, regulators or regulatory agencies. HTH Worldwide shall notify the Covered Member of any circumstance likely to cause such failure or delay as soon as reasonably practicable.

Conduct of Others

The Covered Member waives all claims against HTH Worldwide for any loss resulting from any advice given, services provided or any acts or omissions of any service provider including, without limitation, providers of medical services, transportation, security personnel or legal services who are referred by HTH Worldwide unless due to HTH Worldwide' willful misconduct.

Consequential Damages

In no event shall HTH Worldwide be liable for any incidental, special, consequential or indirect loss, damages, costs, charges, fees or expenses, including without limitation, loss of profits, loss of income, loss of business or loss of use.

Time Limitations

Any and all legal actions and claims arising under this Program shall be barred unless written notice thereof is received by HTH Worldwide within one (1) year of the date of the event giving rise to such action or claim.

Emergency Record

The information in the emergency record is a representative summary of the Covered Member's medical history and not a comprehensive compilation thereof. HTH Worldwide attempts to collect and store accurate information from the Covered Member as provided by them. HTH Worldwide shall not be responsible for errors or omissions which result from or arise out of inaccurate or incorrect information provided by the Covered Member.

Other Limitations

Any information contained herein or provided by HTH Worldwide under these services is general in nature and should not be construed as definitive or binding advice. The personal information obtained herein should not be used as a diagnostic tool or as a history and physical by a treating physician or those acting at the treating physician's direction. The medical information is a representative summary of the Covered Member's medical history and not a comprehensive compilation thereof. HTH Worldwide attempts to collect and store accurate information from the Covered Member as provided. HTH Worldwide is not responsible for errors or omissions, which result from or arise out of inaccurate or incorrect information provided by the Covered Member. Nor shall HTH Worldwide be liable or responsible in any way for the provision of advice, services or treatment of a medical nature (whether or not provided negligently or recklessly) by facilities or other providers not directly employed by HTH Worldwide. HTH Worldwide recommends that the Covered Member consult with a travel-medicine physician prior to traveling internationally.

This Agreement is entered into between the Covered Member and HTH Worldwide, and is not intended by the parties, nor shall it be construed to, have the effect of creating or conferring any third-party beneficiary status or rights hereunder upon the Covered Member or any other person (including family members) who may be eligible for Services provided under the Program.

Fraudulent Statement

Fraud, misstatement or concealment in the statements made by, for or on behalf of the Covered Member prior to or when effecting this Membership, or any fraudulent claim hereunder shall render the Membership null and void and all benefits, indemnities and services shall be forfeited.

Authorization

HTH Worldwide may require Covered Members and their immediate family to give HTH Worldwide written authorization and releases prior to rendering services under the Program.

Subrogation

HTH Worldwide shall be subrogated to any right or claim that the Covered Members may have against a third party and which results in the rendering of services by HTH Worldwide under the Program.

Return to Work/Study

The Member shall be solely responsible for the decision as to whether or not a Covered Member returns to work, school, training program or trip.

Amendment

HTH Worldwide reserves the right, in its sole discretion, to amend all documents, including these Terms and Conditions, with or without notice. Any such amendment shall be effective as to the Covered Member upon thirty (30) days written notice.

Relationship

The relationship of the parties shall be that of independent contractor and not of employment, partnership, joint venture, unless expressly provided otherwise in the Program. Neither party shall have, nor represent that it has, any right or authority to bind the other to assume or create any obligation or responsibility expressed or implied on behalf of the other or in the other's name unless provided in the Program.

The Program is not a contract of insurance nor is HTH Worldwide an ERISA administrator or fiduciary.

Confidential Information, Trade Secrets, Trademarks, Copyrights and Other Property Rights

Each party expressly undertakes to retain in confidence all information and trade secrets transmitted by the other party that has been designated as proprietary and/or confidential, or by the nature of the circumstances surrounding the disclosure, ought in good faith to be treated as proprietary and/or confidential, and will make no use or disclosure of such information or trade secrets except under the terms of the Program, or unless authorized to do so by the disclosing party. HTH Worldwide shall own and have the exclusive right to all data, documents, intellectual property and software used or generated by it with respect to the Service Program and shall have the right to retain copies of any documents provided to it.

Geographic Scope of Service

The services provided by HTH Worldwide under this Program are rendered on a worldwide basis, provided that HTH Worldwide shall be under no obligation to provide the services described to Covered Members located in areas that HTH Worldwide determines present a risk of war (whether declared or undeclared, civil or other hostilities) or where political conditions make the provision of such services impossible or reasonably impracticable; or

Governing Law

This Contract shall be construed and governed by the laws of the Commonwealth of Virginia, United States of America. The venue for all claims and disputes under this Contract, and all lawsuits filed concerning this Contract, shall be maintained in Fairfax County, Virginia, United States of America.

Complete Contract

It is expressly understood and agreed by the parties that the Application and Terms and Conditions are a final expression of the agreement between the parties. There are no promises, agreements, conditions or understandings, either oral or written, between them other than those that are set forth herein. It is further understood and agreed that, unless otherwise provided, no subsequent alteration, amendment, change or addition to the Program shall be binding upon HTH Worldwide unless reduced to writing and signed by an authorized representative of HTH Worldwide.

Headings

Any headings used in this document are inserted solely for the convenience of reference and shall not constitute a part of this Contract, nor shall they affect its meaning, construction or effect.

Notice

All notices hereunder shall be given to HTH Worldwide and to the Subscriber to the address set forth in the Contract. Facsimile notice and signatures are acceptable under this Contract and shall be effective when received by the addressee.