2010 - 2011
The Promotion University 50k & 500k Insurance Plan

Policy No. CLSP0002-10

ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

Post Office Box 189

Libertyville, Illinois 60048

(800) 452-5772

FAX (847) 281-8813

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Visit us and ***enroll on the Web*** *at:*

www.AIPstudentinsurance.com

www.AIPstudentinsurance.com

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HOW DO I ENROLL IN THE STUDENT HEALTH INSURANCE PROGRAM?

1. You may enroll via the Internet at: **www.AIPstudentinsurance.com** using an electronic check or major credit card.
2. You may complete the attached application, along with your credit card number and expiration date, or you may include a check/money order made payable to:

   STUDENT INSURANCE PLAN
   POST OFFICE BOX 189
   LIBERTYVILLE, ILLINOIS 60048

3. You may call us at **(800) 452-5772** and pay by phone.

We accept American Express, Discover, Mastercard, and Visa credit cards, as well as your personal check.

Detach and keep in your possession.

Promotion University 2010-2011
Student Insurance Plan Identification Card
The Company
NOTE: In a life threatening emergency, go to the nearest emergency room for treatment.

Print name and school ID number

This ID card is for identification only. Possession of the card does not guarantee the right to services or other benefits unless the holder is complying with all provisions of the Member Policy and is currently insured on the date of service. Contact the Company to verify coverage.

Notification of Injury or Sickness must be provided to the Company within 30 days after the date of accident or the commencement of Sickness. Bills for which benefit is to be paid must be submitted within 90 days of the date of treatment. Pre-certification is not required.

Policy Number: CLSP0002-10
$25 co-pay on physician visits
$100 co-pay emergency room

Beech Street
A VIANT NETWORK

Direct all claim inquiries and correspondence to:
Claims Office
28085 Ashley Circle, Suite 201
Libertyville, IL 60048
(800) 452-5772
www.AIPstudentinsurance.com

MultiPlan
Medco Health Prescription Services
$15/$25/$35
www.medcohealth.com
Pharmacy Locations/Questions: (800) 400-0136

Note: The attached is a temporary ID card. Once you are enrolled in the insurance plan a permanent ID card will be mailed to you. For a replacement card please call 800-452-5772. You may also print an ID card online at **www.AIPstudentinsurance.com**.

THE PROMOTION UNIVERSITY STUDENT ACCIDENT AND SICKNESS INSURANCE PROGRAM

Compare this plan to coverage you may now have!

The following is a brief description of the benefits of the Student Accident and Sickness Insurance Program which has been designed for all registered students. This plan is underwritten by THE COMPANY. The exact provisions governing this insurance are contained in the Master Policy issued to Promotion University by The Company and may be viewed online at **www.AIPstudentinsurance.com**.

ELIGIBILITY

Any enrolled Promotion University Student taking at least 6 credit hours of classes is eligible to enroll in this insurance plan. INTERNATIONAL STUDENTS (those who are not United States citizens or permanent residents of the United States) ARE REQUIRED to maintain approved comprehensive health insurance coverage continuously while enrolled and attending Promotion University. Students who are enrolled in special classes and take less than 6 credit/contact hours of class work will be determined eligible for these insurance programs if the reduced coursework meets the criteria for the completion of a degree plan or international program as defined and approved by Promotion University. The Company maintains the right to investigate student status and attendance records to verify that Policy eligibility requirements have been met. If The Company discovers that the Policy eligibility requirements have not been met, our only obligation is refund of premium.

Eligible students who enroll may also insure their Dependents. Eligible Dependents are the spouse (residing with Insured student) and unmarried children under 25 years of age, including an unmarried grandchild under 25 years of age. Dependent coverage starts and expires concurrently with that of the Insured student. If the Insured Person is a covered person prior to the moment of birth, the newborn infant will also be covered under the terms of this policy.

The optional benefits available under The Promotion University $500K plan may only be purchased simultaneously and in conjunction with The Promotion University $50K plan, at the time of initial enrollment in the Plan, subject to the same deadline dates. Dependents are eligible to purchase the Optional coverage only if purchased by the student. Coverage must be the same for all family members.

IMPORTANT NOTE REGARDING ELIGIBILITY OF GRADUATE STUDENTS*

The Student Plan offers a $50,000 benefit per condition (Promotion University $50K Plan) or a $500,000 benefit per Policy Year (Promotion University $500K Plan), and both of these options are available to any registered student of Promotion University, as defined under the Eligibility Section above.

A separate plan, the Graduate Student Insurance Plan, is also available to Graduate Students both employed and not employed by Promotion University. This plan can be accessed at **www.AIPstudentinsurance.com**. Eligible Graduate Students may enroll in either the Student Plan outlined in this brochure, or The Graduate Student Insurance Plan (GRAD 500K Plan) which is outlined in a separate brochure. Dependents must be enrolled in the same plan as the student.

*Graduate Student Employees are not eligible for the State contribution until the first of the month following their first 90 days of employment by Promotion University. Graduate students employed by Promotion University for longer than 90 days will receive a State contribution towards their premium payment. These students SHOULD NOT enroll through this website.

***NOTE**: For the first 90 days of employment, prior to becoming eligible for the state contribution towards premium payment, employed Graduate Students may enroll in either The Student Plan, or The Graduate Student Plan. Premium payment will be their responsibility. Graduate Students may enroll in either plan through their Human Resources Office.

IMPORTANT NOTE REGARDING ELIGIBILITY OF INTERNATIONAL STUDENTS

An insurance plan (the INTL Basic 50K Plan) has been designed specifically for International Students. The benefits under this plan may be accessed at **www.AIPstudentinsurance.com**. Eligible International Students may enroll in either the Promotion University 50K Plan or the Promotion University 500K Plan which are outlined in this brochure, or the INTL Basic 50K Plan which is outlined in a separate brochure. Dependents must be enrolled in the same plan as the student.

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at The System becomes effective 12:00 a.m., August 17, 2010. Coverage becomes effective on that date or the date application and full premium for the term of coverage you have selected is received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m, August 16, 2011. Coverage terminates on that date, or if paying other than annually, at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the insured student. *Coverage is in force 24 hours a day, anywhere in the world, for the entire term for which premium has been paid.*

Insured Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, upon written request received by the company, within 90 days of withdrawal from school.

NEWBORN CHILDREN

In the event of the birth of a child to an Insured Person, the child will automatically be a covered Dependent from the moment of birth. Coverage will continue for 31 days. Payment to continue coverage must be remitted within 31 days, or the coverage will terminate for that child at the end of the 31 day period.

PERIODS OF COVERAGE

If paying premiums other than Annual, coverage will be in effect as shown below. Please see premiums list at the end of the brochure.

Full Policy Year	August 17, 2010 through August 16, 2011
Enrollment Ends	October 15, 2010
Policy Year Paid by Semester	
Fall Semester	August 17, 2010 through December 31, 2010
Enrollment Ends	October 15, 2010
Policy Year Paid by Semester	
Spring Semester	January 01, 2011 through May 16, 2011
Enrollment Ends	March 15, 2011
Policy Year Paid by Semester	
Spring & Summer	January 01, 2011 through August 16, 2011
Enrollment Ends	March 15, 2011
Policy Year Paid by Semester	
Summer Semester	May 17, 2011 through August 16, 2011
Enrollment Ends	New Summer Enrollees Only. Enrollment ends June 17, 2011
Policy Year Paid by Quarter	
Quarterly Enrollment	Initial payment due August 17, 2010 subsequent payments due the 17th of November 2010, February 17, 2011, and May 17, 2011.
Enrollment Ends	October 15, 2010, Fall Semester March 15, 2011, Spring Semester
Monthly Payment for Policy Year Coverage (Auto Debit Only)	Initial payment due August 17, 2010 subsequent payments debited from your account on the 17th of each month through July 16, 2011.
Enrollment Ends	October 15, 2010, Fall Semester March 15, 2011, Spring Semester

(1) PROMOTION UNIVERSITY 50K & (2) PROMOTION UNIVERSITY 500K SCHEDULE OF BENEFITS

Deductible, Co-payment and Co-Insurance apply unless stated otherwise

	Co-Insurance IN NETWORK	Co-Insurance OUT OF NETWORK
1. **Deductible** (waived for treatment at Student Health Center) - $250 per policy year		
2. **Covered Percentages**		
At Student Health Center	100%	N/A
Outside Student Health Center	80%	60%
3. **Room and Board**	80%	60%
4. **Intensive Care**	80%	60%
5. **Hospital Miscellaneous Charges**	80%	60%
6. **Dental Accident Expense** $100 per tooth	80%	60%
7. **Nurse Expense**	80%	60%
8. **Surgical Benefits**	80%	60%
9. **Assistant Surgeon Benefit**	80%	60%
10. **Anesthesiology**	80%	60%
11. **Day Surgery Miscellaneous Charges**	80%	60%
12. **Emergency Room and Urgent Care Center** $100 co-pay	80%	60%
13. **Substance Abuse and Mental or Nervous Condition Treatment - Inpatient** 30 days per Policy Year	80%	60%
14. **Substance Abuse and Mental or Nervous Condition Treatment - Outpatient** $2,000 per Policy Year, $25 co-pay	80%	60%
15. **Durable Medical Equipment**	80%	60%
16. **Laboratory, X-ray, Radiation Therapy, Chemotherapy**	80%	60%
17. **Physiotherapy, following surgery or hospital confinement** $25 co-pay	80%	60%
18. **Doctors Visits** $25 co-pay	80%	60%
19. **Consultant** $25 co-pay	80%	60%
20. **Ambulance to $1,000 per trip when due to a medical emergency**	80%	60%
21. **Well Care** (charges for one office visit to a physician each Policy Year) $25 co-pay	80%	60%
22. **Intramural Sports (paid as any accident)**	80%	60%
23. **Club Sports (paid as any accident)** -. to $5,000 per accident	80%	60%
24. **Pre-Existing Condition -** Additional benefits may be available for a pre-existing condition.	80% to $1,000	60% to $1,000

25. Pharmacy Benefits

At Student Health Center 100% to $1,000 per Policy Year, co-pay $15 per prescription

Outside Student Health Center Medco Drug Card to $2,000 per Policy Year, co-pay Generic - $15, Brand - $25, Single Source - $35

Note: If you purchase the Promotion University 500K Plan, the maximum benefit is increased from $50,000 per condition to $500,000 per policy year.

IMPORTANT NOTE

You must meet the eligibility requirements listed in the Eligibility Section. (To avoid a lapse in coverage, your insurance payment must be received within 14 days after the date your coverage terminates, based on the insurance payment method you selected.) It is the student's responsibility to make timely premium payments to the address indicated to avoid a lapse in coverage.

LATE ENROLLMENT

Eligible students and their Dependents will not be allowed to enroll in the Policy after October 15, 2010 for Fall Semester, or March 15, 2011 for Spring Semester and for Summer, all premiums are due and must be postmarked by June 17, 2011, unless proof is furnished that the eligible student or Dependent became ineligible for coverage under another insurance policy, during the thirty (30) days immediately preceding the date of the request for late enrollment in the University's Policy. In such cases, the cost will be the same as it would have been at the beginning of that period, but the effective date will be the date the application is made and the payment is received. The deadlines shown above are ABSOLUTE deadlines. THE 14-DAY GRACE PERIOD DOES NOT APPLY HERE.

REFUND OF PREMIUM

Premiums received by Us will be considered fully earned and non-refundable. Refund of premium will be considered only if the Insured Person enters the Armed Forces.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request and coverage will end as of the date of such entry.

TERMINATION OF INSURANCE

Benefits are payable under the Policy only for those Covered Expenses incurred while the Policy is in effect as to the Insured Person. No benefits are payable for Expenses incurred after the date the Insurance terminates for the Insured Person.

EXTENSION OF BENEFITS

If an Insured Person is totally disabled at the date of discontinuance of the Policy, charges incurred during the continuation of such total disability shall also be included in the term "Expense", but only while they are incurred during the lessor of the duration of such disability or the 90 day period following the discontinuance of the Policy.

CONTINUATION PLAN

If you graduate, leave, or terminate from The System, you may continue to be covered under this plan for the remainder of the Policy year at premiums shown. If continuous coverage is maintained, you can re-enroll in the insurance plan for one additional Policy year at a higher premium subject to the terms of the Policy in effect. Request for continuation and payment must be received no later than 31 days prior to the original termination date. Contact the servicing agent for information. Payment for the entire term of continuation coverage must be selected and paid at the time of initial application.

IMPORTANT FOR ANNUAL ENROLLEES WHO ELECT MONTHLY PAYMENT

Monthly premium payment is available for policy year coverage, but on an AUTOMATIC DEBIT basis only, for the ENTIRE policy year. Students interested in coverage for a term other than the complete policy year should elect an option for payment other than monthly. Please note there is no provision for cancellation other than upon entrance into the Armed Forces. Students who elect monthly payment, whose coverage lapses (because of insufficient funds) during the Policy Year, WILL NOT be permitted to continue the monthly payment option, and will be required to wait until the next open enrollment period to reapply for these benefits.

DESCRIPTION OF BENEFITS

Covered Medical Expense incurred at the Student Health Center will be reimbursed at 100%.

Persons insured under this plan may choose to be treated within, or out of, the Beech Street Preferred Provider Network. The Beech Street Preferred Provider Network consists of Hospitals, Doctors, and other health care providers who have contracted to provide specific medical care at negotiated prices. Reimbursement rates will vary according to the source of care, as described under the Description of Benefits herein.

In order to use the services of a participating provider, you must present your identification card. Your permanent I.D. Card is available through the Student Insurance website at **www.AIPstudentinsurance.com**.

You should always confirm that a Preferred Provider is participating at the time services are rendered (by asking the provider when you make an appointment for service).

A complete listing of Beech Street participating providers is available on the web at **www.AIPstudentinsurance.com or you may call them at (800) 432-1776.**

When an Insured Person uses the services of a Beech Street Preferred Provider, the Covered Expenses incurred will be payable at 80% of the Preferred Allowance after the Deductible has been met. However, when treatment is rendered by providers outside the Beech Street Preferred Provider Network, Expenses will be payable at 60% of Reasonable and Customary charges after the Deductible has been met, unless these medical Expenses are incurred outside of the United States.

Assignment of a network Doctor does not guarantee eligibility or the right to Student Health Benefits.

PERCENTAGE OF COVERED EXPENSES PAYABLE WHEN OUTSIDE OF THE UNITED STATES

The Beech Street Preferred Provider Network is not available when you are traveling outside of the United States. Covered medical Expenses will be reimbursed at 80% of the Reasonable and Customary charge. Medical bills need to be submitted in English, and in United States currency.

THE PROMOTION UNIVERSITY $50K PLAN - BENEFITS TO $50,000 PER CONDITION

If an Insured Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the covered medical Expenses listed herein. 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 $50,000 per Injury or Sickness for the Insured Person. Benefits are subject to the Deductible amount and Coinsurance stated in the Schedule of Benefits, specified benefits and limitations set forth under the Coverage Section, the General Policy Exclusions, the Pre-Existing Condition Limitation, and to all other limitations and provisions of the Policy.

THE PROMOTION UNIVERSITY $500K PLAN - BENEFITS TO $500,000 PER POLICY YEAR

The benefits under The Promotion University $500K Plan begin after the maximum benefit of $50,000 has been reached under The Promotion University $50K Plan. The Company will pay the additional Covered Expenses incurred up to The Promotion University $500K Plan maximum benefit of $500,000 per Policy Year. The total benefit payable under The Promotion University $500K Plan is $500,000 minus the $50,000 in benefits paid under The Promotion University $50K plan. No benefit will be paid under The Promotion University $500K plan for: 1) Room and Board Expense which exceed the semi-private room rate, except for intensive care charges which are payable at 80% of Reasonable and Customary Expenses (In-Network); 2) Dental Treatment; 3) Mental and Nervous Disorders; and 4) Pre-existing conditions as defined.

OUTLINE OF BENEFITS

NOTE: Please refer to Schedule of Benefits on page 4.

DEDUCTIBLE: A Deductible of $250 must first be satisfied for each individual per Policy Year.
NOTE: Submit all medical bills so they can be applied toward the Deductible. The Deductible is waived for covered medical Expenses incurred at the Student Health Center, is $250 per policy year outside of the Student Health Center.

COVERED GENERAL MEDICAL EXPENSES AND LIMITATIONS: Covered Medical Expenses for treatment received outside of the Preferred Provider Network will be limited to the Reasonable and Customary Expenses incurred for services, treatments, and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

PRE-EXISTING CONDITIONS: Expenses related to Pre-Existing Conditions are limited to $1,000 until the limitation period has been satisfied (Additional benefits may be available. Please review the Pre-Existing Conditions and Continuous Insurance sections of this brochure).

HOSPITAL SERVICES: Inpatient Hospital services and Hospital and Doctor 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 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, due to medical necessity of Durable Medical Equipment for therapeutic use. 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.

SURGICAL EXPENSE: (In or out of hospital): Charges will be payable in accordance with the Schedule of Benefits on page 4.

ANESTHESIA EXPENSE: Service of an anesthetist, not employed or retained by the hospital.

ASSISTANT SURGEON: Services of an assistant surgeon, not employed or retained by the hospital, when required by the hospital.

DOCTOR'S EXPENSE, WHEN HOSPITAL CONFINED: Charges for non-surgical services, limited to one visit per day. Physiotherapy by a licensed physical therapist is included in this benefit.

NURSE EXPENSE: Services of a licensed registered nurse when Medically Necessary during a period of Hospital Confinement.

PRE-ADMISSION TESTING: The above Hospital Services Benefit includes payment for outpatient tests performed for a planned preliminary admission as an inpatient for surgery in that same hospital, as long as the surgery is performed within seven (7) days of such tests.

DOCTOR'S EXPENSE, WHEN NOT HOSPITAL CONFINED: Charges for non-surgical services, including outpatient contraceptive services, limited to one visit per day. **The Deductible will not be applied to Doctor's Expense benefit.** Subject to a $25 co-pay at time of service, and applicable co-insurance.

PHYSIOTHERAPY: A licensed physical therapist for a condition that required surgery or Hospital Confinement, provided such therapy is performed (a) during the 30 day period immediately following surgery or hospital confinement; and (b) during the 30 day period following the attending Doctor's approval for physiotherapy. Subject to a $25 co-pay at time of service, and applicable co-insurance.

EMERGENCY ROOM EXPENSE: Charges for emergency outpatient service for Medical Emergency only, unless admitted as an inpatient, subject to a $100 co-payment.

LABORATORY EXPENSE: Charges for laboratory services.

X-RAY EXPENSE: Charges for diagnostic x-ray services.

RADIATION THERAPY AND CHEMOTHERAPY: Charges will be payable.

CONSULTANT'S EXPENSE: Charges for the service of a consulting Doctor, when such service is deemed necessary and ordered by the attending doctor for the purpose of confirming or determining a diagnosis, but not for treatment. Subject to a $25 co-payment.

DENTAL EXPENSE: Up to $100 per tooth for dental treatment of covered Injury to sound, natural teeth.

PREGNANCY/NEWBORN CARE: The Insurer will pay the expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these. 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 Doctor, in consultation with the mother, determines 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. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or Doctor 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.

AMBULANCE EXPENSE: Up to $1,000 per trip for ambulance services required due to a Medical Emergency.

SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS INPATIENT EXPENSE BENEFIT: When Hospital confined, benefits will be paid (as for any other Sickness) not to exceed 30 days confinement expense per Policy year.

SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS OUTPATIENT EXPENSE BENEFIT: Expenses for mental or nervous conditions on an outpatient basis are limited to $2,000 per Policy Year. A $25 co-pay will be applied to each visit. No other benefits are provided for mental or nervous conditions.

SERIOUS MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT: The following coverage is provided for serious Mental and Nervous conditions:

- 45 days of inpatient care;
- 60 visits for outpatient treatment, including group and individual treatment;
- Same limits, deductibles, co-payments and coinsurance as for physical illness.

Serious Mental and Nervous Conditions are defined as: Schizophrenia; paranoia and other psychotic disorders; bipolar disorders (hypomania, manic, depressive, and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorder; obsessive-compulsive disorders; and depression in childhood and adolescence.

INTRAMURAL AND CLUB SPORTS: Benefits are provided for Intramural Sports as any accident but limited to $5,000 per accident for Club Sports.

WELL CARE: Charges for an annual wellness exam, including cost of pap smear. Laboratory charges related to wellness exam are not covered. A $25 co-pay will be applied.

PHARMACY BENEFITS

PRESCRIPTION MEDICATION AT STUDENT HEALTH CENTER: Up to $1,000 will be payable per Policy Year. A $15 co-pay will apply for each 30 day supply. Submit pharmacy receipt for reimbursement.

Prescription contraceptives, including devices, are covered at both the Student Health Center and through the Medco Drug Card.

MEDCO HEALTH — PRESCRIPTION DRUG CARD

Prescriptions purchased through the Medco Health Network including contraceptive medication, will be covered, subject to the applicable co-payment. For a complete list of pharmacy providers, please visit **www.AIPstudentinsurance.com**.

NOTE: The prescription drug card benefit is through the MEDCO Pharmacy Program. The MEDCO Pharmacy Network includes national chains such as CVS and Walgreens, as well as local pharmacies. When you need to have a prescription filled, present your insurance ID card at a participating pharmacy. You will pay a co-payment for your medications. The pharmacy will submit additional charges to the Insurance Company. The plan will pay a maximum of $2,000 per Policy Year towards prescription medication filled through the Medco Pharmacy Benefit. Additional pharmacy benefits at the Student Health Center are shown in the Schedule of Benefits and outlined above.

Medco Drug Card co-payments applicable per prescription:

$15 generic medication
$25 brand medication
$35 single source medication

Co-payment is applied to each 30 day supply.

PHARMACY CO-PAY DEFINITIONS

BRAND DRUG: A medication developed by a pharmaceutical company.
GENERIC DRUG: A medication duplicated by another company once the patent expires.
SINGLE SOURCE DRUG: A brand name drug without a generic equivalent.

ADDITIONAL MANDATED BENEFITS

The State of Texas mandates coverage for the following benefits: mammograms; treatment of diabetes, equipment, supplies and outpatient self-management training for the Insured Person and caretaker; formulas necessary for the treatment of phenylketonuria or other heritable diseases; temporomandibular and craniomandibular joint dysfunction; childhood immunizations (not subject to the deductible or coinsurance); minimum 48 hours hospital stay following mastectomy including initial prosthetic device and reconstructive surgery; prostate cancer screening; screening test for hearing impairment from birth to 30 days old and necessary diagnostic follow-up care through 24 months old (not subject to the deductible); telemedicine and telehealth services; reconstructive surgery for an Insured Person under age 18 to create a normal appearance; colorectal cancer screening; treatment of mental or nervous disorders in a crisis stabilization unit or residential treatment center for a Dependent child, the same as if treatment were provided in a hospital; minimum 24 hours hospital stay following a lymph node dissection for treatment of breast cancer; bone mass measurement for the detection of low bone mass in an osteoporosis qualified individual; and therapies and services as a result of and related to an acquired brain injury. Please see the Policy on file with the University for full details. All Benefits are subject to the terms and conditions of the Policy.

PRE-EXISTING CONDITIONS

"**Pre-existing Condition**" is a Sickness, Injury, or related condition for which a licensed Doctor was consulted; or for which treatment or medication was prescribed within twelve (12) months prior to the Effective Date of the Insured Person's coverage under this Policy.

We will pay a maximum benefit of $1,000 for Covered Charges incurred by an Insured person for the treatment of a Pre-existing Condition. Charges for the treatment of a Pre-existing Condition in excess of this maximum benefit shall be subject to the following limitations:

The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-existing Condition: a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student's effective date, and b) We will pay only for Loss or expense incurred after such twelve (12) consecutive month period.

This limitation will not apply, if during the period immediately preceding the Insured Person's effective date of coverage under the Policy, the Insured Person was covered under The Promotion University Student or GSI Insurance Plan or The Promotion University Employee Insurance Plan for 12 months or covered by prior Creditable Coverage for an aggregate period of 18 months. The Insured Person shall be credited with the time prior Creditable Coverage was in effect at any time during the 18 months preceding the effective date of coverage.

A period of Creditable Coverage will be credited if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the Effective date of the new coverage.

Creditable Coverage means coverage under any of the following:

a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
b) a group health benefit plan provided by a health insurance carrier or health maintenance organization;
c) an individual health insurance policy or evidence of coverage;
d) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
e) Title XIX of the Social Security Act (U.S.C. 1396 et seq.), other than coverage solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);
f) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
g) a medical care program of the Indian Health Service or of a tribal organization;
h) a state health benefits risk pool;
i) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);
j) A public health plan. A public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in this plan, as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Services Act, 42 U.S.C. Sec. 300 gg(c)(1)(I);
k) a health benefit plan under section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e))
l) any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public health Services Act (42 U.S.C. Sec 300gg (c)).

REPATRIATION FOR U.S. STUDENTS

If an Insured Person dies, the Insurer will pay the necessary expenses actually incurred, up to $7,500, for the repatriation of the Insured Person's remains to his/her home residence. 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 Expenses for repatriation of remains require the Insurer's or the Administrator's prior approval.

MEDICAL EVACUATION / REPATRIATION FOR INTERNATIONAL AND STUDY ABROAD STUDENTS

MEDICAL EVACUATION: If an Insured Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to $10,000 for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Insured Person's Home Country. Transportation must be by the most direct and economical route. However, before the Insurer makes any payment, it requires written certification by the attending Doctor that the evacuation is Medically Necessary. Any expenses for medical evacuation require the Insurer's or the Administrator's prior approval.

REPATRIATION OF REMAINS (for International & Study Abroad Students Only): If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to $10,000 for the repatriation of the Covered Person's remains to his/her place of residence in their 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 expenses for Repatriation of Remains require the Insurer's or the Administrator's prior approval.

BEDSIDE VISITS FOR INTERNATIONAL AND STUDY ABROAD STUDENTS: If the Covered Person is Hospital Confined due to an Injury or Sickness for more than seven (7) days while traveling outside his/her Home Country, the Insurer will pay up to a maximum benefit of $2,500 for the cost of one economy round-trip airfare ticket to the place of the Hospital Confinement for one person designated by the Covered Person. No benefits are payable unless the trip is approved in advance by the Administrator.

TRAVEL ASSISTANCE SERVICES FOR ALL STUDENTS

Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriations.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services: Toll Free from U.S. and Canada: 1-800-850-4556 or collect outside the U.S. and Canada, 603-328-1713, 603-898-9159. www.oncallinternational.com

24-HOUR NURSE ADVICE LINE: Wouldn't you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-800-850-4556.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When, because of an Injury, the Insured Person suffers any of the following Losses. Within 365 days from the date of the Accident, We will pay as follows:

For Loss of:	Amount
Life	$5,000
Both hands or both feet or sight of both eyes	$5,000
One hand and one foot	$5,000
One hand and sight of one eye	$5,000
One foot and sight of one eye	$5,000
One hand or one foot or sight of one eye	$2,500
Thumb and index finger of either hand	$1,250

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies. This provision does not cover the Loss if it in anyway results from:

(1) Suicide, attempted suicide, or intentionally self-inflicted Injury;
(2) Physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;
(3) An infection, unless it is caused solely and independently by a covered Accident;
(4) Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or
(5) The Insured Person being legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.

In addition to the above, the provision is subject to the Exclusions as provided.

DEFINITIONS

"**Accident**" means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

"**Coinsurance**" means the percentage of Reasonable and Customary Expenses for which Insured Person is responsible for a covered service.

"**Covered Charge**" or "**Expense**" as used herein means those charges for any treatment, services, or supplies that are: a) for Network Providers, not in excess of the Preferred Allowance; b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; c) not in excess of the charges that would have been made in the absence of this insurance except for institutions, controlled or owned by state and/or local governments, which provide services to indigent and non-indigent patients; and d) incurred while this Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

"**Deductible**" means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

"**Doctor**" as used herein means: a) a legally qualified Doctor licensed by the state in which he or she practices; or b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or c) a certified nurse midwife while acting within the scope of the certification.

"**Domestic Student**" is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

"**Elective Treatment**" means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage. Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic

purulent sinusitis; treatment for weight reduction; infertility; complications arising from cosmetic surgery; circumcision; bunions; hammertoes; and impacted toenails. Elective Treatment includes breast reduction and breast implants except for breast reconstruction following a mastectomy as provided for in the Breast Reconstruction Expense Benefit. Elective Treatment includes immunizations except for childhood immunizations as provided for in the Childhood Immunizations Expense Benefit.

"**Experimental or Investigational Care**" means a service or supply; a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis/ treatment; or b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished. We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

"**Home Country**" means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

"**Hospital**" means a facility which meets all of these tests:

a) it provides inpatient services for the care and treatment of injured and sick people; and b) it provides room and board services and nursing services 24 hours a day; and c) it has established facilities for diagnosis and major surgery (except for a mental institution that contracts with a Hospital for major surgery); and d) it is supervised by a Doctor; and e) it is run as a Hospital under the laws of the jurisdiction in which it is located. Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

"**Hospital Confinement**" means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

"**Injury**" means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

"**Insured Person**" means an Insured Student and his or her covered Dependent(s) while insured under this Plan.

"**Insured Student**" means a student of the Policyholder who is eligible and insured for coverage under this Plan.

"**International Student**" is a student classified as a Non-Immigrant and has not been granted permanent residency status in the United States. For example, students holding visa types: "F" (Student), "J" (Exchange Visitor), "B" (Tourist), or "A" (Diplomat).

"**Loss**" means medical expense covered by this Policy as result of Injury or Sickness as defined in this Policy and other expenses as specifically covered.

"**Medical Emergency**" means the unexpected onset of an Injury or Sickness which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the individual in serious jeopardy; b) serious impairment to bodily functions; c) serious dysfunction of any bodily organ or part; d) serious disfigurement; or e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

A Medical Emergency does not include elective or routine care.

"**Medically Necessary**" a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if: a) it is provided only as a convenience to the Insured Person or provider; b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms; or c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

"**Network Providers**" are Doctors, Hospitals, and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

"**Non-network Providers**" have not agreed to any pre-arranged fee schedules.

"**Preferred Allowance**" means the amount a Network Provider will accept as payment in full for Covered Charges.

"**Reasonable and Customary Expenses**" means fees and prices generally charged within the locality where performed, for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

"**Sickness**" means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or related cause are considered one Sickness.

"**We**", "**Us**", and "**Our**" mean the The Company.

"**You**" and "**Your**" mean the Insured Person.

DETERMINING REASONABLE EXPENSES

Expenses incurred within the PPO Network are based upon negotiated fee schedules with providers. Reasonable Expenses incurred outside of the PPO Network will be based on the Ingenix survey of prevailing fees, valued at the 80th percentile, in the area where the service is provided.

SUBROGATION

If We pay Covered Expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the amount recovered, up to the amount of your benefits We have paid under this Plan. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

EXCLUSIONS AND LIMITATIONS

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. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;
3. Organ transplants, except as specifically provided;
4. Pre-existing Conditions as defined in this Policy;
5. Nonprescription drugs or medicines, except for insulin;
6. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
7. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with interscholastic sports, intercollegiate sports, intercollegiate club sports, and professional sports, except as specifically provided;
8. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved body part, reconstructive surgery because of congenital disease or anomaly of a covered Dependent newborn child;
9. Illness, Accident, treatment, or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, bungee-cord jumping, parachuting or bungi-cord jumping;
10. Correction of congenital defects except as specifically provided;
11. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
12. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;

13. Expense incurred after the date insurance terminated for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
14. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
15. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
16. Injury due to participation in a riot;
17. Charges for which Insured Person's have no legal obligation to pay in absence of this or like coverage;
18. For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brother, and sisters.
19. Personal hygiene/convenience items; telephone consultations, missed appointments, photocopies or medical records, or completion of claim forms; expenses incurred for custodial care or services not needed to diagnose or treat an Injury or Sickness, including but not limited to services related to the activities of daily living;
20. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, artificial insemination, and services or supplies for inducing conception;
21. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
22. Expense incurred for eye examinations, or prescriptions, eye glasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), including eye refractions, vision therapy, multiphasic testing, radial keratotomy, hearing aids, or supplies related thereto or Lasik or other vision procedures except as required for repair caused by a covered Injury;
23. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;
24. Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
25. An amount of a charge in excess of the Reasonable and Customary Expense:
26. Elective Treatment or Elective Surgery, except as specifically provided;
27. Services not Medically Necessary;
28. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
29. Treatment of mental or nervous disorders except as specifically provided;
30. Treatment of alcohol and substance abuse except as specifically provided;
31. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;
32. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism;
33. Medicines not taken in the dosage or for the purpose prescribed by the Insured Person's Doctor;
34. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;
35. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided.

COORDINATION OF BENEFITS

The Policy will coordinate benefits as outlined in the Master Policy.

CONTINUOUS INSURANCE

Persons who have remained continuously insured under the Policy, and have prior Creditable Coverage, will be covered for a Pre-existing Condition that originated while so continuously insured, provided continuous insurance is maintained.

Previously Insured persons who are re-enrolled for coverage within 63 days of termination of prior coverage, will have maintained continuous coverage. A person who is not so re-enrolled will have a break in continuous insurance and will not be covered for any Pre-existing Condition that originated before or during such break.

The total benefits payable under the Policy, for any one Injury or Sickness, shall not exceed the "specified" Maximum Benefit amounts.

The purpose and intent of this provision will apply separately to the Optional Major Medical Benefits. This Policy may be replacing a Prior Plan with another insurer.

"Prior Plan" means the group or blanket accident and sickness Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy.

"Injury" or "Sickness" shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

No Benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Previously insured Eligible Students and Dependents must re-enroll for coverage within 30 days of the end of the prior coverage in order to avoid a break in the coverage for conditions which existed in prior Policy Years. Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.

COMPLAINT RESOLUTION

Insured Persons, Preferred Providers, Non-Preferred Providers, or their representatives with questions or complaints, may call the Customer Service Department at (800) 452-5772. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

ALTERNATIVE COVERAGE

For those students not enrolled in this Accident and Sickness plan, there is an Accident Only plan available. Call (800) 452-5772 for more information.

HOW DO I OBTAIN MY IDENTIFICATION CARD?

1. You may detach and retain the temporary Identification Card provided on the brochure.
2. You may obtain your permanent Identification Card on the Internet at **www.AIPstudentinsurance.com**. Click on Access Online Services, Print ID Card, Verify Coverage. You will need to provide your name, student identification number, and your birth date. If you experience any difficulty, please call us at (800) 452-5772.
3. You may call (800) 452-5772 and request that your permanent Identification Card be mailed to you.

HOW DO I FILE MY CLAIM UNDER THE STUDENT INSURANCE PROGRAM?

1. Secure the necessary medical treatment. A listing of Preferred Providers is available at: **www.AIPstudentinsurance.com**
2. Obtain itemized bills from your Doctor or provider.
3. Complete a claim form. A claim form is available at: **www.AIPstudentinsurance.com**
   If your provider has already mailed the bills to the Claims Administrator, you may complete the claim form and email it to the

Claims Administrator. If you have not yet mailed the medical bills to the Claims Administrator, print a claim form, complete it, and mail the completed claim form along with your medical bills to the Claims Administrator at:

The Company
28085 Ashley Circle, Suite 201
Libertyville IL, 60048
(800) 452-5772

Written notice of claim must be given within 30 days after the occurrence, or commencement of any loss covered by the Policy. Bills for which benefit is to be paid must be submitted within 90 days of the date of treatment.

4. Any additional medical bills submitted for reimbursement to the Claims Administrator must show your name, student identification number, name of college or university, and description of medical condition.

Only one claim form, per condition, needs to be completed.

You may check the status of a claim you have already filed at: www.AIPstudentinsurance.com and click "Check Claims Online". (If you experience difficulty retrieving your records please call 800-452-5772.)

HOW CAN I RECEIVE ASSISTANCE WITH A QUESTION OR PROBLEM?

Please call the Administrator, at (800) 452-5772, Monday through Friday, between the hours of 7:00 a.m. to 7:00 p.m. Central Time, or email us: office@AIPstudentinsurance.com. We appreciate hearing from you with your comments, questions, and concerns.

Any provision of the Policy, or the brochure, which is in conflict with the statutes of the state in which the Policy is issued, will be administered to conform with the requirements of the state statutes.

Please keep this brochure as a general summary of the insurance. The Master Policy contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between the brochure and the Policy, the Master Policy will govern and control the payment of benefits. This brochure is based on Policy CLSP0002-10.

NOTE: This coverage is transferable between schools within Promotion University.

Medical Benefits Underwritten by:

The Company

Claims should be mailed to:
Claims Office
28085 Ashley Circle, Suite 201
Libertyville IL, 60048
(800) 452-5772

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Direct All Inquiries To:
(800) 452-5772

ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

Post Office Box 189
Libertyville, Illinois 60048
(800) 452-5772 • FAX (847) 281-8813
(e-mail) office@AIPstudentinsurance.com
*Visit us and **enroll on the Web** at:*
www.AIPstudentinsurance.com

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION
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.

This is your Health Information Privacy Notice from THE COMPANY (referred to as We or Us). This notice is effective April 14, 2003. This notice provides you with information about the way in which We protect Personal Health Information ("PHI") that We have about you. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also explains your rights with respect to PHI. The Health Insurance Portability and Accountability Act ("HIPAA") requires Us to: Keep PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

Use and Disclosure of PHI: We obtain PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, We may use and/or disclose PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed:

For Health Care Payment Purposes: For example, We may use and disclose PHI to administer and process payment of benefits under your insurance coverage, determine eligibility for coverage, claims or billing information, conduct utilization reviews, or to another entity or health care provider for its payment purposes.

For Health Care Operations Purposes: For example, We may use and disclose PHI for underwriting and rating of the plan, audits of your claims, quality of care reviews, investigation of fraud, care coordination, investigate and respond to complaints or appeals, provider treatment review and provision of services.

For Treatment Purposes: For example, We may use and disclose PHI to health care providers to assist in their treatment of you. We do not provide health care treatment to you directly.

For Health Services: For example, We may use your medical information to contact you to give you information about treatment alternatives or other health related benefits and services that may be of interest to you as part of large case management or other insurance related services.

For Data Aggregation Purposes: For example, We may combine PHI about many insureds to make plan benefit decisions, and the appropriate premium rate to charge.

To You About Dependents: For example, We may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.

To Business Associates: For example, We may disclose PHI to administrators who are contracted with Us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.

Additional Uses or Disclosures: We may also disclose PHI about you for the following purposes: To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests. To law enforcement officials for limited law enforcement purposes. To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this. To your personal representatives appointed by you or designated by applicable law. For research purposes in limited circumstances. To a coroner, medical examiner, or funeral director about a deceased person. To an organ procurement organization in limited circumstances.

To avert a serious threat to your health or safety or the health or safety of others. To a governmental agency authorized to oversee the health care system or government programs. To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request. To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.

To public health authorities for public health purposes. To appropriate military authorities, if you are a member of the armed forces. In accordance with a valid authorization signed by you.

HIPAA NOTICE (CONTINUED)

Your Rights Regarding PHI That We Maintain About You: You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to Us in care of Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

You have the right to inspect and copy your PHI. If you request a copy of the information, We may charge a fee for the costs of copying, mailing or other supplies associated with your request. You have the right to ask Us to amend the PHI that is contained in a "designated record set", e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. We may deny the request if the PHI is accurate and complete or if we did not create the PHI. You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before April 14, 2003 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, We may charge you the cost of providing the list. We will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided by Us will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions. You have the right to request to restrict the way We use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI We disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If We do agree, We will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply. Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to Us at the address at the end of this notice. You have the right to request that We communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice by calling Us at 800-452-5772 or submitting the request to THE COMPANY, c/o Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Us. When filing a complaint, include your name, address and telephone number and We will respond. All complaints must be submitted in writing to THE COMPANY, c/o Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office. You may also contact the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Changes To This Notice: We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to insureds. If you have any questions regarding this notice, please call 800-452-5772 or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and We will respond.

ALL QUESTIONS AND REQUESTS REGARDING YOUR RIGHTS UNDER THIS NOTICE SHOULD BE SENT TO:

THE COMPANY
c/o Associated Insurance Plans International, Inc.
Post Office Box 189, Libertyville, IL 60048
Attn: HIPAA Privacy Office

OPTIONAL DENTAL/VISION/PHARMACY DISCOUNT PLAN

(Additional premium required)

No Claim Forms
No Waiting Periods
No Pre-existing Conditions
No Deductibles or Maximums
No Age Restriction
Discount is immediate at time of service
Over 100,000 participating providers nationwide

The Co-Health Group Collegiate plan has been specifically designed to meet the needs of today's College and University students, whether they are incoming freshmen, graduate, evening students, international or domestic students attending Promotion University.

The Co-Health Benefit Plan provides discounts in certain health care areas not normally reimbursed by insurance. In the "Collegiate Plan" we are offering the Vision, Dental and Pharmacy Discount Program as a single package of Benefits, or you may purchase discounts for pharmacy or vision separately. Here's how the plan works.

This is not an Insurance Plan. The Co-Health Group Collegiate Plan is a Discount Care Plan offering discounts and savings for Vision, Dental and Prescription Pharmacy expenses.

Each of the benefit programs (Vision, Dental, and Prescription Pharmacy) has a network of Providers (for example, the participating dentists in the Dental Plan.) As a member of the Plan you can go to any of the providers listed and purchase their products or services on a negotiated discount basis. You get your discount/savings on the spot. There are no exclusions for "pre-existing" conditions. There are no claim forms to fill out and no paperwork to be filed. Simply show your Co-Health membership card at the time of your scheduled appointment or at a participating pharmacy.

The discounts you will receive are substantial and these savings can be very important to you. The services that make up the Collegiate Plan (Vision, Dental and Pharmacy) are also the three most common areas where you will have unexpected expenses. With our Benefits, you can substantially reduce your out of pocket expenses, and as an added bonus, you can use our plan benefits anywhere in the United States, except the State of Washington.

You simply show your Co-Health ID Card and get your discount on the spot.

Annual Premiums - enroll anytime throughout the year at www.AIPstudentinsurance.com. You do not need to purchase health insurance to enroll in the optional dental/vision/pharmacy discount plan.

ANNUAL PREMIUMS	**Credit Card or Internet Payment**	**Check By Mail**
Dental/Vision/Pharmacy		
Student Only	$72.00	$62.00
Family	$98.00	$88.00
Vision & Pharmacy		
Student Only	$50.00	$40.00
Family	$71.00	$61.00
Vision		
Student Only	$25.00	$15.00
Family	$30.00	$20.00
Pharmacy		
Student Only	$25.00	$15.00
Family	$30.00	$20.00

OPTIONAL DENTAL AND VISION INSURANCE FOR YOU AND YOUR FAMILY

(Additional premium required)

Underwritten by Security Life Insurance Company of America

- ***Freedom to Use Dentist of Your Choice***
- **Up to $2,000 Annual Maximum**
- **Coverage for Adult Sealants**
- **Three Plan Design Options**
- **No Waiting Periods for Most Services**
- **Optional Vision Coverage for Additional Premium**

PERSONAL DENTAL PLANS

Dental Benefits	Elite Plan	Premier Plan	Select Plan
Class A - Preventive Services			
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	100%	100%	75%
Benefit Year Two	100%	100%	85%
Benefit Year Three and Each Benefit Year Thereafter	100%	100%	100%
Deductible - Lifetime per Insured	$50	$50	$50
Waiting Period	None	None	None
Class B - Basic Services			
X-rays, Fillings, Simple Extractions			
Benefit Year One	35%	35%	25%
Benefit Year Two	65%	50%	35%
Benefit Year Three and Each Benefit Year Thereafter	80%	65%	50%
Deductible - Lifetime per Insured	$50/year	$50/year	$50/year
Waiting Period	None	None	None
Class C - Major Services			
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	15%	10%	10%
Benefit Year Two	50%	25%	25%
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	50%
Deductible - Lifetime per Insured	$50/year	$50/year	$50/year
Waiting Period	None	None	None
Class D - Orthodontic Services			
Straightening of Teeth (for children under age 19)			
Benefit Year One	N/A	0%	N/A
Benefit Year Two	N/A	0%	N/A
Benefit Year Three and Each Benefit Year Thereafter	N/A	50%	N/A
Deductible - Lifetime per Insured	—	None	—
Waiting Period	—	24 months	—

PERSONAL DENTAL PLANS (CONTINUED)

Dental Benefits	Elite Plan	**Premier Plan	Select Plan
Calendar Year Maximum for Classes A, B and C Combined	$1,000	$1,000	$1,000
Calendar Year Max. for Class C-Major Services	$500	$500	$500
Calendar Year Max. for Class D	—	$500	—
Lifetime Max. Per Child for Class D	—	$1,000	—
*** Class B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.**			
☆CALENDAR YEAR MAXIMUM INCREASE OPTIONS			
Option One (1) $1,500/Class C - Major Services limited to $750	☆$1,500	☆$1,500	☆$1,500
Option Two (2) $2,000/Class C - Major Service limited to $1,000	☆$2,000	☆$2,000	☆$2,000
****Optional Vision Benefits Rider (Not a Stand-Alone Benefit)**			
Class A - Vision Exams - 1/year Benefit Year One and Each Benefit Year Thereafter **No Waiting Period**	100%	85%	85%
Class B - Lenses and Frames - 1 pair every 2 years Benefit Year One and Each Benefit Year Thereafter **15 Month Waiting Period**	50%	50%	50%
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses) Benefit Year One and Each Benefit Year Thereafter **15 Month Waiting Period**	50%	50%	50%
Calendar Year Deductible	$50/year	$50/year	$50/year
Calendar Year Maximum for Classes A, B and C	$200	$150	$150

☆Optional Feature
You may increase your Calendar Year Maximum Benefit, per individual, for an additional monthly fee. If you elect this feature, your Calendar Year Maximum for Major Services (Class C) will also increase. You must indicate your election of this feature on the enrollment form.

The above plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and dependent will have their own Benefit Year beginning with their specific effective date of coverage. This plan reimburses at the above percentages for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses.

QUESTIONS? PLEASE CALL 800-452-5772.
You do not need to purchase health insurance to enroll in the optional dental and vision insurance plan. Enroll online at www.AIPstudentinsurance.com.

PRIMESTAR PERSONAL DENTAL PREMIUM RATE TABLE FOR EFFECTIVE DATES MARCH 1, 2010 THROUGH OCTOBER 1, 2010

Monthly premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.

RATE CHART			Texas Zip Code: 776-777 Area 1	Any Other Texas Zip Code Area 2
UNDER AGE 65	ELITE	Applicant Only	$ 27.00	$ 30.00
		Applicant + Spouse	$ 56.00	$ 61.00
		Applicant + Child(ren)	$ 62.00	$ 66.00
		Applicant + Family	$ 95.00	$ 103.00
	PREMIER	Applicant Only	$ 23.00	$ 25.00
		Applicant + Spouse	$ 47.00	$ 51.00
		Applicant + Child(ren)	$ 56.00	$ 60.00
		Applicant + Family	$ 84.00	$ 91.00
	SELECT	Applicant Only	$ 20.00	$ 23.00
		Applicant + Spouse	$ 41.00	$ 46.00
		Applicant + Child(ren)	$ 43.00	$ 47.00
		Applicant + Family	$ 67.00	$ 75.00
65 AND OVER	ELITE	Applicant Only	$ 30.00	$ 32.00
		Applicant + Spouse	$ 62.00	$ 67.00
	PREMIER	Applicant Only	$ 25.00	$ 27.00
		Applicant + Spouse	$ 52.00	$ 56.00
	SELECT	Applicant Only	$ 22.00	$ 25.00
		Applicant + Spouse	$ 46.00	$ 49.00
OPTIONAL PREMIER & SELECT VISION COVERAGE FOR ALL AGES		Applicant	$ 5.00	$ 5.00
		Applicant + Spouse	$ 10.00	$ 10.00
		Applicant + Child(ren)	$ 10.00	$ 10.00
		Applicant + Family	$ 13.00	$ 13.00
OPTIONAL ELITE VISION COVERAGE FOR ALL AGES		Applicant	$ 6.00	$ 6.00
		Applicant + Spouse	$ 13.00	$ 13.00
		Applicant + Child(ren)	$ 13.00	$ 13.00
		Applicant + Family	$ 17.00	$ 17.00

Call for rates or view online at **www.AIPstudentinsurance.com**.

STUDENT INSURANCE PLAN

Yes, I wish to participate in the Student Health Insurance Plan. My check or money order payable to Student Insurance Plan for the coverage indicated below is enclosed.

Annual 08-17-10 to 08-16-11	$50K Plan $50,000 Maximum Per Condition	**$500K Plan (includes benefits under A&M $50K Plan)
Student Only	☐ $1,335	☐ $ 1,809
Student & Spouse	☐ $6,013	☐ $ 8,111
Student & Children	☐ $3,168	☐ $ 4,292
Student, Spouse & Children	☐ $7,789	☐ $10,541

*One Semester Fall, 08-17-10 to 12-31-10 Spring, 01-01-11 to 05-16-11	$50K Plan $50,000 Maximum Per Condition	**$500K Plan (includes benefits under A&M $50K Plan)
Student Only	☐ $ 544	☐ $ 734
Student & Spouse	☐ $2,415	☐ $3,254
Student & Children	☐ $1,277	☐ $1,727
Student, Spouse & Children	☐ $3,126	☐ $4,226

*Spring & Summer 01-01-11 to 08-16-11	$50K Plan $50,000 Maximum Per Condition	**$500K Plan (includes benefits under A&M $50K Plan)
Student Only	☐ $ 811	☐ $1,095
Student & Spouse	☐ $3,618	☐ $4,877
Student & Children	☐ $1,911	☐ $2,585
Student, Spouse & Children	☐ $4,683	☐ $6,335

*Quarterly 08-17-10 to 11-16-10 11-17-10 to 02-16-11 02-17-11 to 05-16-11 05-17-11 to 08-16-11	$50K Plan $50,000 Maximum Per Condition	**$500K Plan (includes benefits under A&M $50K Plan)
Student Only	☐ $ 344	☐ $ 462
Student & Spouse	☐ $1,513	☐ $2,038
Student & Children	☐ $ 802	☐ $1,083
Student, Spouse & Children	☐ $1,957	☐ $2,645

*Summer Only 05-17-11 to 08-16-11	$50K Plan $50,000 Maximum Per Condition	**$500K Plan (includes benefits under A&M $50K Plan)
Student Only	☐ $ 344	☐ $ 462
Student & Spouse	☐ $1,513	☐ $2,038
Student & Children	☐ $ 802	☐ $1,083
Student, Spouse & Children	☐ $1,957	☐ $2,645

Monthly AUTOMATIC DEBIT ONLY (debited on the 17th of each month through July 17, 2011)	$50K Plan $50,000 Maximum Per Condition	**$500K Plan (includes benefits under A&M $50K Plan)
Student Only	☐ $ 121	☐ $ 161
Student & Spouse	☐ $ 511	☐ $ 686
Student & Children	☐ $ 274	☐ $ 368
Student, Spouse & Children	☐ $ 659	☐ $ 888

*NOTE: Renewal premium notices will be mailed to the address provided, however, it is your responsibility to submit premium prior to expiration date in order to avoid a lapse in coverage.

** This benefit may be added at initial payment only. Once you have selected either The Promotion University $50K Plan or The Promotion University $500K Plan, you must continue with the coverage selected for the entire policy year.

Insurance costs shown include an administrative fee.

PROMOTION UNIVERSITY
STUDENT INSURANCE AUTOMATIC PAYMENT AUTHORIZATION 2010-2011

I request and authorize THE COMPANY and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account.

DRAFT DATE: _____ **(Will be debited on the 1st each month)**

DRAFT AMOUNT:_____

Check One: ☐ Checking Account ☐ Savings Account

_____
NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

_____
ADDRESS OF BANK

_____
CITY STATE

_____
NAME OF INSURED, APPLICANT (PRINT)

_____
NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED

_____
DEPOSITOR SOCIAL SECURITY NUMBER

_____
DEPOSITOR DRIVER'S LICENSE NUMBER

_____
DEPOSITOR STATE

_____
RELATIONSHIP TO INSURED

_____
SIGNATURE OF DEPOSITOR DATE

AUTOMATIC PAYMENT FROM YOUR CHECKING ACCOUNT REQUIRES A COPY OF A VOIDED CHECK (PLEASE DO NOT SEND A DEPOSIT SLIP)

☐ ***Please automatically charge my Student insurance premiums to my account identified below for this entire policy year.***

☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMEX

Card Number _____ Expires:_____
Last 3 numbers on the reverse side of the credit card. Located within the signature box _____ ***(For Authorization Purposes)***

Print name of cardholder _____

Cardholder phone number _____

Amount authorized to debit_____for Student Health Insurance.

Cardholder signature _____
Today's Date

FOR HOME OFFICE USE ONLY
BANK TRANSIT NUMBER _____
DEPOSITOR'S ACCOUNT NUMBER _____

PROMOTION UNIVERSITY
STUDENT INSURANCE PLAN ENROLLMENT CARD 2010-2011

Please Print Legibly

Student's Name _____
(First) (M) (Last)

Student I.D. # _____

Social Security # _____

Campus attending (IMPORTANT) _____

Billing Address:

Street _____ Apt. No. _____

City _____ State _____ Zip _____

☐ Male ☐ Female Date of Birth _____

Telephone No. _____

Alternate Telephone No. _____

Do you have any other medical insurance? ☐ YES ☐ NO.

If yes, name of insurance company: _____

E-mail Address (IMPORTANT!) _____

Spouse's Name _____

Date of Birth (mm/dd/yy) _____

Social Security # _____

Child _____ Date of Birth (mm/dd/yy)_____

Social Security # _____

Child _____ Date of Birth (mm/dd/yy)_____

Social Security # _____

Child _____ Date of Birth (mm/dd/yy)_____

Social Security # _____

I have carefully read the brochure and elect to enroll as indicated. Rates are not pro-rated other than as listed. PLEASE MAKE SURE TO INDICATE COVERAGE DESIRED ON REVERSE SIDE.
My remittance in the amount of $_____is enclosed.

☐ **IMPORTANT...PLEASE CHECK HERE IF YOUR ARE AN INTERNATIONAL STUDENT**
Type of Visa_____ Home Country_____
☐ **IMPORTANT...PLEASE CHECK HERE IF YOUR ARE A MEDICAL STUDENT**
☐ **IMPORTANT...PLEASE CHECK HERE IF YOUR ARE A GRADUATE STUDENT**

MONTHLY ENROLLEES...Please indicate which month you desire your coverage to begin _____(Month) Monthly enrollees: please complete Automatic Payment Authorization Form

QUARTERLY ENROLLEES...Please indicate which quarter you desire your coverage to begin:
☐ August 17 ☐ November 17 ☐ February 17 ☐ May 17

Make check or money order payable to Student Insurance Plan.
Mail this enrollment card along with premium to:
Post Office Box 189, Libertyville, IL 60048

☐ Please charge my Student Health insurance: (Minimum charge of $25). You must re-enroll in the insurance plan each term.

☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMEX

Card Number _____

3 or 4 digit security code _____ Expiration Date _____

Print name of cardholder_____

Cardholder signature _____

Please Charge $_____ for Student Health Insurance.

Student signature _____

NOTE: You may enroll "On-line" and pay your premium by electronic check or major credit card at **www.AIPstudentinsurance.com**