

Kettering University

(“the Policyholder”)

**1700 W. Third Avenue
Flint, MI 48504**

Student Accident and Sickness Insurance Plan

2009–2010

The Plan is Underwritten by
National Union Fire Insurance Company
of Pittsburgh, Pa.,
with its principal place of business in
New York, NY (“the Company”)

Administrator Policy Number: AMH0068070
Underwriter Reference Number: CAS9710647

Keep this brochure as a general summary of the insurance

This brochure is only a brief description of the coverage available under policy series S30494NUFIC-MI. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions, some of which may not be included in this brochure. Full details of the coverage are contained in the Master Policy on file at the University. If any discrepancy exists between the contents of this brochure and the Policy, the Policy will govern in all cases.

ELIGIBILITY

Kettering University requires that all active students, domestic and international, obtain and maintain health insurance coverage while enrolled at the University. To assure compliance, all students are automatically enrolled in the University-sponsored Student Accident and Sickness Insurance Plan. The annual cost for the Student Health Insurance Plan is \$885. Students enrolled in the plan will be charged \$442.50 on each semester's tuition invoice. The plan includes medical evacuation, repatriation and travel assistance services.

Students enrolled in the Plan may also insure their eligible Dependents. Dependent coverage must be purchased at the same time that the student enrolls in the Plan. Eligible Dependents include any of the following: spouse residing with the Covered Student; unmarried children under 19 years of age who reside with the Covered Student, or 19 years of age but less than 23 years of age if dependent upon the Covered Student and enrolled as a full time student at an accredited institution of higher learning. Dependent coverage may be purchased at www.maksin.com/KetteringU.aspx; click on "Dependent Enrollment Form."

Newborn children and adopted children are covered for Injury or Sickness from birth until 31 days old. Coverage may be continued for that child when the Company is notified in writing within 31 days from the date of birth and required premium is paid. Please contact Maksin Management Corp at 1-877-775-5430 for enrollment information.

Students who are currently insured by a health insurance policy (their own or through their parents) may waive Kettering University's endorsed insurance plan with proof of other comparable insurance. Online waiver can be accessed at www.maksin.com/KetteringU.aspx. Study abroad students with comparable health insurance coverage may enroll online to separately purchase the AIG Travel Assist program for a \$48 annual fee (not pro-rated).

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been and continue to be met. If the Company discovers that the Policy eligibility requirements have not been or are not being met, its only obligation is to refund premium, less any claims paid. A Covered Student must meet the eligibility requirements each time he or she pays to continue insurance coverage.

WAIVER AND ENROLLMENT DEADLINES

Students that currently have comparable health insurance coverage may waive Kettering University's endorsed Student Health Insurance Plan. Online waivers must be completed by the last day of the waiver deadline (see below). If the waiver deadline is ignored, the student will be responsible for the insurance premium. To access the online waiver form:

1. Go to www.maksin.com/KetteringU.aspx
2. Click on the "Waiver Form"
3. Complete the online form and submit waiver.

Waiver Deadlines:

Submitted waiver information will be verified with your insurance company as part of the insurance verification process. If insurance status cannot be verified, the waiver will be revoked and the insurance premium will be charged to your student account.

Summer/Fall Semester Deadline: July 31, 2009
Winter/Spring Semester Deadline: January 30, 2010
Incoming B-Section Freshmen & Transfer
Students Only: Waiver Period: September 16,
2009 to October 30, 2009

No waivers will be accepted after the last day of the waiver deadline for the term. The insurance charge will not be removed from your tuition bill without an approved waiver.

Optional Dependent Enrollment Deadlines:

Summer/Fall Semester: July 31, 2009
Winter/Spring Semester: January 30, 2010

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable plan may elect to enroll for coverage under this Plan within 31 days of the date of ineligibility/loss of coverage under the plan. No waiver or enrollment form will be accepted beyond the deadline for each term of coverage. The only enrollment exceptions are the following qualifying events: 1) adding a new spouse or Dependent child (within 31 days of marriage, birth, adoption); 2) enrolling as a new student (within 31 days of enrollment at the University); or 3) ineligibility/loss of coverage under another creditable plan (within 31 days of loss of coverage). Please contact Maksin Management Corp at 1-877-775-5430 for enrollment information.

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on July 1, 2009 and terminates at 11:59 p.m. on June 30, 2010. Refunds of premiums are allowed only upon entry into the armed forces. The Company will refund the unearned, pro-rata premium to such person upon written request and receipt of appropriate proof of service within 30 days of leaving school.

Coverage effective dates for Covered Students and their eligible Dependents will be the latter of: the effective date of the Master Policy; the effective date of the term of coverage for which premium has been paid for the Covered Person;

for a qualifying event, the date eligibility requirements are met and for which correct premium is paid. Coverage will continue during the period for which premium is paid.

Coverage terminates at the earliest of: the termination date of the Master Policy; the last day of the term of coverage for which premium has been paid for the Covered Person; the date the Covered Person ceases to be eligible to purchase the insurance; or the date a Covered Person enters full time, active military service.

It is the Covered Person's responsibility to assure timely renewal payments to avoid a lapse in coverage. A lapse in coverage will subject claims to the pre-existing condition clause.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under the Policy is "Creditable Coverage" under Federal Law. When coverage terminates, the Covered Person can request a Certificate of Coverage that is evidence of coverage under the Policy. The Covered Person may need such a certificate if he she becomes covered under a group health plan or other health plan within 63 days after the coverage under the Policy terminates. If the subsequent health plan excludes or limits coverage for medical conditions the Covered Person had before enrolling, this Certificate may be used to reduce or eliminate those exclusions or limitations.

In order to obtain a Certificate of Creditable Coverage, please contact Maksin Management Corp, Two Aquarium Drive, Suite 200, Camden, NJ 08103 or call 1-877-775-5430.

NON-DUPLICATION OF COVERAGE

If benefits are payable under more than one provision under the Policy, then benefits will be provided only under the provision providing the greater benefit.

EXTENSION OF BENEFITS AFTER TERMINATION

If the Covered Person is Hospital confined on the date his or her insurance ends, the term Eligible Expenses includes charges incurred after the date such insurance ends. Eligible Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 30 days after the date such insurance ends or until discharged from the Hospital, whichever is earlier, subject to any maximum amounts stated in the Policy.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

STATE MANDATED BENEFITS

The State of Michigan mandates coverage for the following benefits: Treatment of Alcoholism and Substance Abuse in an Intermediate Care Facility and Outpatient Care Facility up to \$3,919 per Policy Year; Treatment of Diabetes to include equipment, supplies and outpatient self-management training; Reconstructive Breast Surgery following a Mastectomy; Off-Label Drugs; and Antineoplastic Therapy.

The Policy will cover any other applicable mandated benefits as required by the State of Michigan.

DEFINITIONS

“Accident” means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

“Allowable Charges” means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

“Covered Person” means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

“Covered Student” means a student of the Policyholder who is insured under the Policy.

“Doctor” means: (a) legally qualified physician licensed by the state in which he or she practices; and (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 such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s Immediate Family Member.

“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 Covered Person’s effective date of coverage.

Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; botox injections; treatment of infertility and routine physical examinations.

“Eligible Expense” means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

“Emergency Medical Condition” means a Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests

itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:

- (a) the Covered Person's life could be in serious jeopardy;
- (b) bodily functions would be seriously impaired;
- (c) a body organ or part would be seriously damaged;
- (d) serious disfigurement; or
- (e) serious jeopardy to the health of the fetus.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

“Experimental/Investigational” means a drug, device or medical care or treatment that meets the following:

- (a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- (b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
- (c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;
- (d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with

a standard means of treatment or diagnosis; or

- (e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

“Hospital” means a facility which meets all of these tests:

- (a) it provides in-patient 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; 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; and
- (f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders or substance abuse. The term “Hospital” includes: (a) an ambulatory surgical center or ambulatory medical center; (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Immediate Family Member(s)” means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Covered Person or provider; or
- (b) it is not the appropriate treatment for the Covered 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; or
- (d) it is Experimental/Investigational or for research purposes; or
- (e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or

- (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
- (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of 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.

“Pre-Existing Condition” means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 12 months prior to the Covered Person’s effective date of coverage under the Policy or a pregnancy existing on the Covered Person’s effective date of Coverage under the Policy.

“Reasonable and Customary (R&C)” means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date.

“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person’s coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

SCHEDULE OF BENEFITS

The Plan pays Eligible Expenses at applicable co-insurance percentage after any applicable co-payments. Benefits listed as payable in percentages are based on percentage of Eligible Expenses subject to applicable benefit maximums.

ELIGIBLE MEDICAL SERVICES	IN-NETWORK	NON-NETWORK
Aggregate Lifetime Benefits Maximum (all conditions) (in-network and non-network maximum are combined)	\$1,000,000	\$1,000,000
Aggregate Policy Year Maximum Benefits (all conditions) (in-network and non-network maximum are combined)	\$100,000	\$100,000
Policy Year Maximum Benefit per Injury or Sickness (in-network and non-network maximum are combined)	\$100,000	\$100,000
Policy Year Co-Insurance	80% of Allowable Charges	60% of Reasonable & Customary (R&C) Charges
Policy Year Maximum Out-of-Pocket Limit: When the Covered Person's share of the Eligible Expenses reaches a \$5,000 Out-of-Pocket Limit per Policy Year, the Company will pay 100% of Eligible Expenses subject to applicable maximums. Co-payments and amounts above applicable maximums do not apply toward the Out-of-Pocket Limit.		
INPATIENT BENEFITS		
Room and Board and general nursing care (up to the average semi-private room rate except ICU)	80% of Allowable Charges	60% of R&C Charges
Hospitalization Expense Benefit (such as the cost of the operating room; laboratory tests and x-ray examinations [including professional fees]; anesthesia; drugs [excluding take-home drugs] or medicines; dressings; and other Medically Necessary and prescribed Hospital expenses)	80% of Allowable Charges After \$50 Co-Payment per Confinement	60% of R&C Charges
Registered Nurse (for private duty nursing when prescribed by the attending Doctor)	80% of Allowable Charges	60% of R&C Charge
Pre-Admission Testing	80% of Allowable Charges	60% of R&C Charges
Physiotherapy and Acupuncture (in-network and non-network maximum are combined)	80% of Allowable Charges Up to \$2,500 Max. Per Policy Year	60% of R&C Charges Up to \$2,500 Maximum Per Policy Year
Surgical Services (Doctor's Charges)	80% of Allowable Charges	60% of R&C Charges
Assistant Surgeon	80% of Allowable Charges	60% of R&C Charges
Anesthesia	80% of Allowable Charges	60% of R&C Charges
Doctor / Consultant Visits	80% of Allowable Charges	60% of R&C Charges
Mental or Nervous Disorders & Alcohol or Substance Abuse (in-network and non-network maximum are combined)	Same as any other Sickness Up to \$5,000 Maximum per Lifetime	Same as any other Sickness Up to \$5,000 Maximum per Lifetime
OUTPATIENT BENEFITS		
Day Surgery Miscellaneous (Facility Charges) (such as the cost of the operating room; laboratory tests and x-ray examinations [including professional fees]; anesthesia; drugs [excluding take-home drugs] or medicines; dressings; and other Medically Necessary and prescribed facility expenses)	80% of Allowable Charges After \$50 Co-Payment per Visit	60% of R&C Charges
Surgical Services (Doctor's Charges)	80% of Allowable Charges	60% of R&C Charges
Assistant Surgeon	80% of Allowable Charges	60% of R&C Charges
Anesthesia	80% of Allowable Charges	60% of R&C Charges
Doctor's / Consultant's Office Visit	80% of Allowable Charges After \$20 Co-Payment per Visit	60% of R&C Charges
Emergency Medical Condition (use of Emergency Room and Supplies)	80% of Allowable Charges After \$50 Co-Payment per Visit	60% of R&C Charges
Diagnostic Services (including professional fees) – X-Ray and Laboratory Services, Imaging, Chemotherapy / Radiation Therapy. For Covered Students Only benefits include an annual routine Pap Smear Screening.	80% of Allowable Charges After \$50 Co-Payment Per Visit	60% of R&C Charges
Mental or Nervous Disorders (includes diagnostic testing only for learning disabilities for student only, one per year when recommended by a Psychologist) (in-network and non-network maximum are combined)	Same as any other Sickness Up to \$500 Maximum per Lifetime	Same as any other Sickness Up to \$500 Maximum per Lifetime
Alcohol or Substance Abuse -Outpatient and Intermediate Care Facility (in-network and non-network maximum are combined)	Same as any other Sickness Up to \$3,919 Max. Per Policy Year	Same as any other Sickness Up to \$3,919 Maximum Per Policy Year
Outpatient Prescription Drugs However obtained, all outpatient prescription drugs are subject to the outpatient prescription drug maximum. The Preferred Providers for prescriptions are through Informed Rx, an SXC company. For the complete listing of providers, please go to www.maksin.com .	100% of Eligible Expenses: Up to \$2,000 Aggregate Maximum per Policy Year \$10 co-pay for generic drugs and \$20 co-pay for brand name drugs	
Maternity Care	Same as any other Sickness	Same as any other Sickness
OTHER SERVICES		
Ambulance Service	80% of Eligible Expenses	80% of Eligible Expenses
Durable Medical Equipment / Braces and Appliances (only upon a Doctor's written prescription)	80% of Allowable Charges	60% of R&C Charges
Dental (Injury to Sound, Natural Teeth)	100% of Eligible Expenses - Up to \$500 Maximum Per Policy Year	
Treatment of Injuries Sustained as a Result of a Covered Motor Vehicle Accident (in-network and non-network maximum are combined)	Same as any other Injury Up to \$10,000 Max. Per Policy Year	Same as any other Injury Up to \$10,000 Maximum Per Policy Year
Intramural/Interscholastic or Club Sports Injury	80% of Allowable Charges	60% of R&C Charges

EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for Loss or Expenses incurred:

1. as a result of dental treatment, or dental x-rays, except for treatment resulting from Injury to Sound, Natural Teeth as specifically provided in the Policy.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses; hearing aids; or prescriptions or examinations for such except as required for repair caused by a covered Injury. Eye refraction is not covered.
4. as a result of an 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.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
10. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, illegal occupation, insurrection or civil commotion.
11. for Elective Treatment or elective surgery, elective abortion.
12. for any services rendered by a Covered Person's Immediate Family Member.
13. for a treatment, service or supply which is not Medically Necessary.
14. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
15. for treatment of temporomandibular joint dysfunction (TMJ).
16. for loss due to voluntary use of any drug, narcotic or controlled substance, unless prescribed by a Doctor.
17. for Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Doctor.
18. for surgery and/or treatment of: acne; allergy, including allergy testing and anti-toxins; biofeedback-type services; corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof, unless due to Injury occurring while coverage is in force; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; Attention Deficit Disorder; nonmalignant warts, moles and lesions; premarital examinations; sexual reassignment surgery and related therapy; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including supplies, treatment and testing thereof; preventive medicines or vaccines, except where required for the treatment of Injury; smoking cessation; tubal ligation; vasectomy; and weight reduction.
19. for routine physical examinations, and routine testing; preventive testing or treatment and screening exams, unless specifically provided in the Policy; health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, other than Hospital nursery expense of a Dependent newborn baby, unless specifically provided in the Policy.

20. in connection with birth control, except prescription contraceptives; sterilization or sterilization reversal, including surgical procedures and devices.
21. as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place, except in a Driver's Education Program.
22. for organ, tissue and cell transplants.
23. for outpatient physiotherapy.
24. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports; scuba diving; hang gliding; parachuting; bungee jumping.
25. for treatment in the Hospital emergency room that is not due to an Emergency Medical Condition.
26. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
27. for home health care.
28. for hormone treatment or hormone therapy not related to the treatment of Sickness.

ACCIDENTAL DEATH AND DISMEMBERMENT

If a Covered Person sustains any of the following losses as the result of a covered Accident, within 26 weeks after the date of such Accident, the Company will pay the amount shown below. "Member" means hand, foot or eye. Loss of a hand or foot means complete severance through or above the wrist or ankle joint. Loss of an eye means the total, permanent loss of sight in the eye. Loss of a thumb or index finger means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand). The Principal Sum is the maximum amount payable under this benefit for all losses resulting from any one accident.

Maximum Amount:

- Student – 10,000
- Spouse – \$5,000
- Child – \$ 1,000

For Loss of	Percentage of Maximum Amount
Life	100%
Two or more members	100%
One member	50%
Thumb and Index Finger of Same Hand	25%

PREFERRED PROVIDER ORGANIZATION

Preferred Provider Organization: First Health
Toll-Free Telephone Number: 800-226-5116
First Health Website: www.firsthealth.com

In an effort to control insurance medical costs and enhance payment, this Plan has implemented a Preferred Provider Organization (PPO) of Hospitals, facilities and Doctors who have contracted to provide service at a discounted, negotiated rate to Covered Persons eligible for benefits. The PPO for Kettering University is First Health.

If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not guarantee that all providers at the Hospital are participating providers. In addition, if a Covered Person is referred by a participating provider to another facility or provider, it does not mean that the provider or facility to which the Covered Person is referred is also a participating provider. It is the Covered Person's responsibility to verify that the provider is part of the PPO. A list of providers in the First Health Network is also available for review via the "Preferred Provider Lookup" that can be accessed at www.maksin.com/KetteringU.aspx

FULL EXCESS COVERAGE

If a Covered Person incurs Eligible Expenses for any of the services on the Schedule of Benefits, the Company will pay the Eligible Expenses incurred, subject to the Deductible amount and Covered Percentage (if any), that are in excess of expenses payable by any other health care plan, regardless of any Coordination of Benefits provision contained in such health care plan.

PRE-EXISTING CONDITIONS

Pre-existing Conditions are not covered for the first 12 months following a Covered Person's effective date of coverage under the Policy. This limitation will not apply if:

1. The Covered Person has been covered under the Policyholder's prior Policy for more than 12 consecutive months immediately preceding the effective date of coverage under the Policy; or
2. (a) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. The Company will credit the time the individual was covered under prior Creditable Coverage; (b) whose most recent prior Creditable Coverage was under an employer group health plan; and (c) who

is not eligible for coverage under any other group health plan, Medicare or Medicaid; and (d) who does not have other health insurance; and (e) who accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

Pre-existing Conditions does not apply to:

- (a) a newborn Dependent child; or
- (b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under the Policy.

CREDIT FOR PRIOR COVERAGE: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under the Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

- (a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
- (c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;

- (e) a medical care program of the Indian Health Service or of a tribal organization;
- (f) a state health benefits risk pool;
- (g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
- (h) a public health plan as defined by federal regulations; or
- (i) a health benefit plan under section 5(e) of the Peace Corps Act.

CONTINUOUS COVERAGE

Continuously insured means a person who has been continuously insured under the Policy and prior Student Health Insurance policies issued to the school. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for expenses payable under prior policies in the absence of the current Policy. Previously insured Dependents and students must re-enroll for coverage in order to avoid a break in coverage within 31 days of the end of the prior coverage to maintain coverage for conditions which existed in prior Policy Years. Once a break in coverage in continuous insurance occurs, the definition of Pre-Existing Condition will apply in determining coverage of any condition that existed during such break.

SUBROGATION

If the Company has paid benefits to the Covered Person for Injuries received in a covered Accident, and in their opinion a third party may be liable, the Company will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of proceeds in any form from or on behalf of the third party including but not limited to recovery from any person, corporation, entity, no-fault coverage, uninsured coverage, other insurance policies or fund which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer his or her rights to the Company. The Company will exercise such rights on his or her behalf. He or she further agrees to furnish the Company with all relevant information and documents.

For those students **not** insured under the Student Accident and Sickness Insurance Plan, the following benefits under the Travel Assist Program may be purchased separately for a \$48 annual premium. You may enroll for these benefits at www.maksin.com/KetteringU.aspx.

For Covered Students under the Student Accident and Sickness Insurance Plan, the following benefits are included in the health insurance premium.

REPATRIATION OF REMAINS BENEFIT
\$25,000 Maximum Amount

If a Covered Person suffers loss of life due to Injury or Emergency Sickness while outside his or her home country, the Company will pay, subject to the Policy limitations, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person. Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible. Travel Assist must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Assist in advance.

EMERGENCY EVACUATION BENEFIT
\$25,000 Maximum Amount

The Company will pay, subject to the Policy limitations, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. Travel Assist must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Assist in advance.

Please refer to TRAVEL ASSIST section of this brochure for information on how to contact Travel Assist for medical evacuation and repatriation benefit assistance.

Covered Persons are also entitled to the following travel and medical assistance services. This program is not affiliated with, nor endorsed by, National Union Fire Insurance Company of Pittsburgh, Pa.

TRAVEL ASSIST
Procedures on How to Access Travel Assist
24-hour Assistance Call Center

How to Contact Travel Assist:

- Inside the U.S. and Canada, dial 1-800-626-2427 toll-free.
- Outside the U.S. and Canada:
 - Request an international operator.
 - Ask the international operator to connect to an AT&T operator.
 - Request the AT&T operator to place a collect call to Houston, TX, USA at 713-267-2525.
- Our fax number is 01-713-974-3422.

When to Contact Travel Assist:

- Call Travel Assist when you require medical assistance or have a medical emergency.
- Call Travel Assist for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Assist whenever there is a question.

Travel Assist is available 24-hours-a-day/7-days-a-week/365-days-a-year.

Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home. The Travel Assist Medical Staff consists of full-time, onsite Registered Nurses and Emergency Doctors who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide to Travel Assist when you call:

- Advise Travel Assist who you are insured by.
- Provide your Policy number, AMH0068070/CAS9710647
- Advise Travel Assist regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Assist needs to call you back.

Description of Services

Information/General: These services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Assist can also provide information on available currency exchange rates, local Bank/Government holidays, and, by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Assist also provides emergency message storage & relay and translation services.

- * Visa & Immunization
- * Weather & Exchange Rates
- * Environmental & Political Warnings

Technical: These services provide assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Assist can arrange cash transfers & vehicle return in the event of Sickness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

- * Legal Referral
- * Embassy/Consulate Information
- * Lost/Stolen Luggage & Personal Effects Assistance
- * Lost Document Assistance
- * Cash Transfer Assistance
- * En-route Travel Assistance
- * Claims-related Assistance
- * Telephone Interpretation

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Assist's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include Doctor/dental/Hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

Medical Assistance:

- * Medical Referral
- * Out-patient Assistance
- * In-patient Assistance

STUDENT ASSIST SERVICES

Concierge Services: You receive the comforts, care, and attention of Student Assist's Personal Assistance Coordinators available 24/7 to respond to virtually any request – large or small.

Personal Security Assistance: You can feel safe and secure with Student Assist's Personal Security Assistance at home or while traveling. To activate personal security services, please log on to: www.aig.com/personalsecurity. For initial setup, your login is "9710647" and the password is "security".

For more details visit
www.maksin.com/KetteringU.aspx.

CLAIM FILING PROCEDURES

Claims forms can be accepted directly from Doctors or facilities if the claim form includes the name of the Covered Person, Covered Student's school name, date of services, diagnosis, treatment procedure and billed charges. Proof of loss must be furnished within 90 days after the date of such loss.

Online claim forms can be accessed at www.maksin.com/KetteringU.aspx. Fill in the necessary information, have the attending Doctor complete his/her portion of the form, or attach all other itemized medical and Hospital bills and mail to:

Maksin Management Corp

PO Box 2647

Camden, NJ 08101-2647

Customer Service Toll-Free Telephone:
1-877-775-5430

Questions regarding benefits, specific claim information and periods of coverage should be directed to the address or Customer Service phone number listed above.

Visit www.maksin.com/KetteringU.aspx to access the following functions:

- Online Waiver
 - Dependent Enrollment Form
 - *AIG Travel Assist* Form
- (voluntary for students **not** enrolled in the Student Accident & Sickness Insurance Plan)

Review pertinent account information:

- Verification of Insurance
- Download Online ID Card
 - Check Claim Status
 - Policy Brochure
 - PPO Link

At the Maksin Group, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more privacy information, please go to the website at www.maksin.com/KetteringU.aspx.

NON-RENEWABLE ONE YEAR TERM INSURANCE

The Policy is non-renewable one year term insurance. Similar coverage may be purchased for the following academic year. It is the Covered Student's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.