2010 - 2011
PROMOTION UNIVERSITY STUDENT ACCIDENT AND INTRAMURAL SPORTS PROGRAM

POLICY NO. CLSP0005-10

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

www.AIPstudentinsurance.com

TABLE OF CONTENTS

INTRODUCTION

This is a brief description of the Accident Medical Expense benefits available for students of Promotion University. This plan is underwritten by THE COMPANY. The exact provisions governing this insurance are contained in the master policy (referred to below as "this policy" or "the policy") issued to Promotion University and may be viewed online at **www.AIPstudentinsurance.com**.

ELIGIBILITY

All registered students of Promotion University are eligible to participate in the Insurance program described in this brochure. **24 hour accident benefits are provided by payment of premium shown for all groups.** Coverage for specific intramural and club sports listed under Scope of Coverage is available by payment of the additional premium shown on the application. Premiums are calculated per sport to be insured, per category.

TERM OF COVERAGE AND PREMIUM PAYMENT

Coverage begins at 12:00 AM on 08/17/10, or the date premium is paid, if later, and terminates at 11:59 PM on 08/16/11, or the date through which premium is last paid, if earlier.

Premiums are not pro-rated for late enrollment. Students participating in the play and practice of intramural or club sports, who wish to be covered for the play and practice of intramural or club sports, must pay the additional premium shown under Scope of Coverage for each sport to be covered.

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.

REFUND OF PREMIUM

Premiums received by Us will be considered fully earned and nonrefundable. Refund of premium will be considered only if the Insured Person ceases to be eligible for the insurance. Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.

SCOPE OF COVERAGE

Group A - Intercollegiate play of club and intramural archery, bowling, cycling, horseshoes, golf, and ultimate frisbee only.

Group B - Intercollegiate play of club and intramural fencing, handball, polo, racquetball, roadrunners, sailing, men's soccer, women's soccer, softball, volleyball, and water polo.

Group C - Intercollegiate play of club and intramural basketball, flag football, gymnastics, ice hockey, in-line hockey, judo, lacrosse, pistol, rodeo, rugby, trap and skeet, water-skiing, weightlifting, and wrestling.

Please complete application and submit premium shown for each sport to be insured. If 24 hour accident coverage is desired, the premium for Group A must be paid in addition to the premium submitted for each sport for which coverage is desired.

DESCRIPTION OF BENEFITS
ACCIDENT MEDICAL EXPENSE

When Injury requires treatment, payment will be made, after satisfying the deductible of $100, for Covered Medical Expenses resulting from an accident occurring during the term insured. Covered Medical Expenses are those expenses for Doctors and surgeons, Hospital Confinement, physical therapy, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressing, use of an ambulance, and other Reasonable and Customary medical Expenses incurred during the term Insured, subject to the limits and conditions shown in (a)-(d) below. The Maximum Benefit is $50,000 for each accident.

(a) Payment for outpatient prescription drugs is limited to $100 per accident.

(b) Braces and appliances are payable only if administered during initial treatment, limited to $200 per accident.

(c) Payment for crutches and wheel chairs is limited to $25 per accident.

(d) Dental treatment of Injury to sound, natural teeth is payable up to $400 per accident.

DEFINITIONS

"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.

"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.

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. 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;
8. Illness, Accident, treatment, or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, bungee jumping, parachuting or bungi-cord jumping;
9. Correction of congenital defects except as specifically provided;
10. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
11. 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;
12. 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;

13. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
14. 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;
15. Injury due to participation in a riot;
16. Charges for which Insured Person's have no legal obligation to pay in absence of this or like coverage;
17. 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, brothers, or sisters.
18. 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;
19. 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;
20. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
21. 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 lasix or other vision procedures except as required for repair caused by a covered Injury;
22. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;
23. Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
24. An amount of a charge in excess of the Reasonable and Customary Expense:
25. Elective Treatment or elective surgery, except as specifically provided;
26. Services not Medically Necessary;
27. 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;
28. Treatment of mental or nervous disorders except as specifically provided;
29. Treatment of alcohol and substance abuse except as specifically provided;
30. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile 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-cystic acne; 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; and learning disabilities or disorders or Attention Deficit Disorder;
33. Voluntary or elective abortion; except as specifically provided;
34. Medicines not taken in the dosage or for the purpose prescribed by the Insured Person's Doctor;
35. 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;
36. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided.

Promotion University Accident Plan
Student Insurance Enrollment Card

2010 • 2011

The Company

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

Date of Birth_____

Social Security # _____

Address _____(Apt. #)_____

City _____ ST _____ Zip_____

Telephone Number _____

Email address _____

Please indicate your student status:
☐ Graduate Student ☐ International Student ☐ Freshman
☐ Sophomore ☐ Junior ☐ Senior

I have carefully read the brochure and elect to enroll as indicated below. Rates are not pro-rated other than as listed. PLEASE MAKE SURE TO CHECK COVERAGE DESIRED. Make check or money order payable to Student Insurance Plan. Mail this enrollment card along with premium payment to: Student Insurance Plan located at: Post Office Box 189, Libertyville, Illinois 60048. My remittance in the amount of $_____ is enclosed.

PLEASE SEE SCOPE OF COVERAGE IN THIS BROCHURE FOR COVERAGE DESIRED.

Option to Student
Please indicate the number of sports to be covered in EACH Group as outlined under Scope of Coverage

Group A	***Group B**	***Group C**
☐ $96 x _____ # of sports	☐ $154 x _____ # of sports	☐ $288 x _____ # of sports

TOTAL PREMIUM DUE: $_____ premiums due

* See SCOPE OF COVERAGE Section of this Brochure for a list of sports to be covered under each Group.

Please list all Intramural and Club Sports to be insured for the 2010-2011 policy year below.

_____ _____
_____ _____
_____ _____
_____ _____

_____
Signature of Student Date

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. We may also take subrogation action directly against the third party. Our Reimbursement and Subrogation rights are subject to deduction of 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.

TERMINATION OF INSURANCE

Benefits are payable under this 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, except as may be provided under Extension of Benefits.

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.

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 "Print ID Card". 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 Insurance Company, you may complete the claim form and email it to the Insurance Company. If you have not yet mailed the medical bills to the Insurance Company, print a claim form, complete it, and mail the completed claim form along with your medical bills to the Insurance Company at:

   Claims Office
   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 by the Insurance Company 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.

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.

DENTAL AND VISION

Please call (800) 452-5772 to request a brochure. Visit our website at **www.AIPstudentinsurance.com**, scroll to the bottom of the page and click on the Dental and Vision Section.

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 Standard Time, or email us through the Insurance Information Internet Site, **www.AIPstudentinsurance.com**. We appreciate hearing from you with your comments, questions, and concerns.

Underwritten by:
THE COMPANY
28085 Ashley Circle, Suite 201
Libertyville, IL 60048
(800) 452-5772

DIRECT ALL INQUIRIES TO:

Associated Insurance Plans International, Inc.

Post Office Box 189
Libertyville, Illinois 60048
(800) 452-5772
FAX (847) 281-8813
email: office@AIPstudentinsurance.com
www.AIPstudentinsurance.com

Student Insurance Identification Card 2010-11
THE COMPANY
NOTE: In a life threatening emergency, go to the nearest emergency room for treatment.

Print name and school ID number

Policy Number: CLSP0005-10
Direct all claim inquiries and correspondence to:
Claims Office
28085 Ashley Circle, Suite 201
Libertyville, IL 60048
www.AIPstudentinsurance.com
(800) 452-5772

Beech Street A VIANT NETWORK

MultiPlan

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 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.