



University of Louisiana at Lafayette

(the "Policyholder")

2013-2014

Student Accident Insurance Plan

(the "Plan")

Customer Service

Questions: 1-888-722-1668

Email: lafayette@studentinsurance.com

www.studentinsurance.com

**Insurance 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: CHH8047954

Underwriter Reference Number: SRG9495499

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ELIGIBILITY

All domestic undergraduate registered students carrying seven (7) hours in the spring and fall and four (4) hours in the summer and all domestic graduate students carrying six (6) hours in the spring and fall and three (3) hours in the summer will be automatically enrolled in the Plan and the insurance premium will be assessed in their tuition through the domestic student insurance fees.

Note: Students enrolled for the preceding semester will be covered under the Plan during the semester break if the student registers for the following semester. Students registering in the spring and planning to continue in the fall will be considered a continuing student; in order to maintain coverage, such student must pay the summer insurance premium.

All enrolled participants in the UL Lafayette Year-Round Visiting Groups: Boarding Programs and Day Camps will be automatically enrolled in the Plan and the insurance premium will be assessed in their group insurance fees.

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on August 18, 2013 and it terminates at 11:59 p.m. on August 17, 2014.

The coverage of an eligible Student who enrolls for coverage under this Plan shall take effect on the latest of the following dates: (1) the Policy effective date; (2) the day after the date for which the first premium for the Covered Person's coverage is paid; or (3) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits on file with the Policyholder.

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:

- (a) the date this Plan terminates;
- (b) the last day for which any required premium has been paid; or
- (c) the date on which the Covered Student withdraws from the school because of:
 - (1) entering the armed forces of any country (premiums will be refunded on a pro-rata basis when written request is made within 30 days of leaving school); or
 - (2) withdrawal from school during the first 31 days of the period for which enrollment was made; or
 - (3) departure from the Policyholder's school for his or her home country. (premiums will be refunded on a pro-rata basis only upon written proof from the Policyholder that the Covered Student is no longer an eligible person).

If withdrawal from school is for other than (1) or (3) above, no premium refund will be made. Students will be covered for the policy term for which they are enrolled and for which premium has been paid.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

EXCESS PROVISION

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same Injury, on a provision of service basis or on an expense incurred basis under any other valid and collectible insurance. If the other valid and collectible insurance provide benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose policy or service contract has been in effect for the longer period of time at the date of such Injury.

For purposes of this Plan, a Covered Person's entitlement to other valid and collectible insurance will be determined as if this Plan did not exist and will not depend on whether timely application for benefits from other valid and collectible insurance is made by or on behalf of the Covered Person.

Benefits under this Plan will be reduced to the extent that benefits for expenses are covered by any other valid and collectible insurance whether or not a claim is made for such benefits.

UNIVERSITY OF LOUISIANA AT LAFAYETTE STUDENT ACCIDENT PLAN SCHEDULE OF BENEFITS

When, by reason of Injury, a Covered Person incurs Eligible Expenses for Hospital, surgical or medical treatment, services or supplies, the Company will pay the Eligible Expenses incurred up to the \$15,000 Aggregate Maximum Amount. The Company must receive proof that the Eligible Expenses were solely the result of an Injury sustained by the Covered Person. The first such Expense must be incurred within 30 days after the date of the Accident causing the Injury. The Company will pay for covered expenses which are the direct result of the Accident, and from no other cause, within 52 weeks of the Accident.

Eligible Expenses include the following:

- (a) Hospital most common semi-private room and board (or room and board in an intensive care unit); Hospital miscellaneous services (including, but not limited to, use of operating room or emergency); or use of an ambulatory medical center or ambulatory surgical center;
- (b) services of a doctor;
- (c) private duty nursing services rendered by a registered nurse (R.N.) or licensed practical nurse (LPN);
- (d) use of an ambulance to or from a Hospital;
- (e) laboratory tests;
- (f) radiological procedures;
- (g) anesthetics and the administration thereof;
- (h) blood, blood products and artificial blood products, and the transfusion thereof;
- (i) physiotherapy;
- (j) occupational therapy;
- (k) medicines, drugs obtained only with a doctor's written prescription or any other therapeutic services and supplies so ordered by the doctor.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Company will pay the benefit below for Injuries to a Covered Student: (a) caused by an Accident which happens while a student is covered by the Plan; and (b) which directly, and from no other cause, result in any of the losses listed below within 100 days of the Accident that caused the Injury.

The amount of this benefit is shown in the table below.

For Loss of	Maximum Amount
Life.....	\$3,000
Both Hands or Both Feet.....	\$3,000
Sight of Both Eyes	\$3,000
One Hand and One Foot	\$3,000
One Hand and the Sight of One Eye.....	\$3,000
One Foot and the Sight of One Eye.....	\$3,000
One Hand or One Foot	\$1,500
The Sight of One Eye	\$1,500
Thumb and Index Finger of Same Hand.....	\$750

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means the total, irrevocable loss of the entire sight in that eye. “Loss” of speech means total and irrecoverable loss of the entire ability to speak. “Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

“Severance” means the complete separation and dismemberment of the part from the body.

If a Covered Student suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.

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.

“Covered Person” means a Covered Student while coverage under this Plan is in effect.

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

“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 Plan is in force as to the Covered Person.

“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; (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; and (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.

“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.

It does not include emergency services necessary to screen and stabilize a Covered Person. Services for such Emergency Medical Condition shall not require any prior authorization before benefits under this Plan become payable. When the benefit payment for such services has been authorized, the Company will not subsequently retract its authorization after benefit payment has been made or reduce payment for an item, treatment or service furnished in reliance upon approval, unless approval was based upon a material omission or misrepresentation about the Covered Person’s health condition made by the provider of emergency services. For immediately required post-evaluation or post-stabilization services, the Company will be available 24 hours a day, 7 days a week, to facilitate review.

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.

“Reasonable and Customary” 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.

“Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

EXCLUSIONS

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

1. as a result of dental treatment, except for treatment resulting from Injury to sound natural teeth.
2. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such; radial keratotomy or laser surgery; hearing aids; or prescriptions or examinations for such except as required for repair caused by a covered Injury.
3. 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 commercial scheduled airline.
4. for Injury resulting from war or act of war, declared or undeclared.
5. as a result of an Injury for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
6. as a result of committing or attempting to commit an assault or felony or participation in a riot or civil commotion.
7. for any services rendered by a Covered Person's immediate family member.
8. for a treatment, service or supply which is not Medically Necessary.
9. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
10. for personal items or services such as television, telephone or transportation.
11. for loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of narcotics unless administered on the advice of a doctor.
12. for Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs, while operating a motor vehicle.
13. for routine physical examinations, health examinations or preschool physical examinations.
14. for Injury resulting from: the practicing for, participating in intercollegiate sports activity, including travel to and from the activity and practice.
15. for treatment of illness, disease or infection, except bacterial infection due to accidental cut or wound or accidental ingestion of contaminated substances.

CLAIMS PROCEDURE

1. **Written proof of loss must be given to the Company within 90 days after the date of loss.** To submit the written claim form go to www.studentinsurance.com, log into the Covered Student's account and click on 'student options'. The claim form can be submitted online electronically.
2. **Please be sure that the provider photocopies the Covered Student's insurance card.**
3. The Covered Student should retain one copy of all claims information submitted for his or her records.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (Hospital, Doctor and others), UNLESS A PAID RECEIPT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

CLAIMS ADDRESS:

Educational Markets Mail Center
P.O. Box 26050
Overland Park, KS 66225

CLAIMS QUESTIONS:

AIG, Educational Markets
Toll Free: 1-888-722-1668

IMPORTANT INFORMATION

This brochure is a brief description of the Student Health Insurance Plan available under policy series S30494NUFIC-LA. The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file with the Policyholder. If there is any conflict between the contents of this document and the Policy, the Policy will govern in all cases. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.