

WINTHROP UNIVERSITY

2009-2010

Student Health Insurance Program

underwritten by:

Standard Security Life Insurance Company
of New York
(a New York Stock Life and Health Company)

Policy # SSH0000140

www.studentinsurance.com

Serviced by:



PEARCE & PEARCE INC.
STUDENT INSURANCE SPECIALISTS SINCE 1948...

Customer Service

Claims Questions: 1-888-722-1668

Eligibility Questions: 1-888-622-6001

Email: winthrop@studentinsurance.com

Designed especially for:

Students of Winthrop University who are Undergraduate Students taking 6 or more credit hours or are a Graduate or Professional Student enrolled in the graduate or professional degree program, taking at least one graduate level course, in good academic standing and making appropriate progress toward graduation.

AND

Dependents of Covered Students. Eligible Dependents are the Legal Spouse and/or unmarried dependent children under 19 years of age living with or principally supported by the Covered Student; or 19 but less than 23 if (a) dependent upon the Covered Student for support; and (b) a full-time student as defined by the school he or she attends, including college, vocational, technical, vocational-technical or trade school or institute.

ONLINE SERVICES

(a SECURE site for all of your insurance needs)

- Go online at www.studentinsurance.com
- Search for your institution
- On this secure site, you can:
 - Enroll
 - Enroll Spouses and Dependents
 - Search for Providers and Hospitals
 - Update your account information
 - View questions and answers about your insurance
 - View claims information
 - View a Summary of Benefits

2009-10 Student Health Insurance Program Premiums

2009-10 Student Health Insurance Program Premiums

Premiums:	Annual (08/15/09-08/14/10)	Fall (08/15/09-01/07/10)	Spring/Summer (01/08/10-08/14/10)	
Student	\$1,069.00	\$434.00	\$635.00	Monthly Bank
Spouse	\$1,525.00	\$631.00	\$914.00	Drafts are also
Each Child	\$1,272.00	\$528.00	\$764.00	Available

PREMIUM REFUNDS WILL BE CONSIDERED ONLY IF REQUESTED WITHIN 31 DAYS OF EFFECTIVE DATE OF COVERAGE TERM ELECTED OR IF THE COVERED PERSON BECOMES FULL TIME ACTIVE DUTY IN ANY ARMED FORCES. PREMIUMS PAID WITHIN OPEN ENROLLMENT PERIODS ARE NOT PRO-RATED

Coordination of Benefits Provision: The Student Health Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverages under which you are enrolled shall not exceed 100% of the cost of the covered services.

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.

Important Information

This brochure is a general summary of the coverage. The Policy on file at the University and at the Pearce & Pearce website (www.studentinsurance.com) contains all of the provisions, exclusions, limitations, definitions, and qualifications of your Plan benefits, some of which may not be included in this summary. If any discrepancy exists between this summary and the Policy, the Policy will govern and control the payment of benefits. This plan also covers applicable Mandated Benefits as required by the State of South Carolina.

Form # SCC 08/09

Referrals

Student Health Services referral is required except for:

1. A Medical emergency. (If clinically appropriate, the Covered Persons is expected to return to the Student Health Services for follow-up care).
2. When the Student Health Services is closed and a Sickness or Injury requires immediate treatment.
3. When medical care is required when the Covered Person is more than 30 miles from the Student Health Services.
4. When medical care is required and the Covered Person, for whatever reason, is not eligible to use the Student Health Services.
5. When services are rendered at another facility during break or vacation period.
6. Maternity Care.
7. Mental Health and Psychiatric Care.
8. Covered Spouse and Dependent children.

Deductibles and Copays apply to all services rendered outside of the Student Health Services.

Claims Procedures

Please call 1-888-722-1668 for pre-notification of all hospital confinements and day surgery prior to admission.

1. Provider must photocopy the Covered Person's new insurance card. PPO Providers will submit the Covered Person's claims.
 2. Claims must be submitted within 45 days.
 3. Submit a completed claim form.
 4. Claim forms can be obtained from the Student Health Services, from the claims office (1-888-722-1668) or from: www.studentinsurance.com
 5. The Covered Person should get a copy of REFERRAL FORM for necessary care not available at the Student Health Services.
 6. The Covered Person should retain one copy of claims information submitted for his or her records.
- PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (Hospital, Doctors, and others), UNLESS A PAID RECEIPT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

Eligibility *

You are eligible for coverage if you are a student enrolled at Winthrop University and:

1. are an Undergraduate Student taking 6 or more credit hours; or
2. are a Graduate or Professional Student enrolled in the graduate or professional degree program, taking at least one graduate level course, in good academic standing and making appropriate progress toward graduation.

Dependents of Covered Students can also purchase coverage. Eligible Dependents are the Legal Spouse and/or unmarried dependent children under 19 years of age living with or principally supported by the Covered Student; or 19 but less than 23 if (a) dependent upon the Covered Student for support; and (b) a full-time student as defined by the school he or she attends, including college, vocational, technical, vocational-technical or trade school or institute.

***Students with an ADA qualifying disability can apply for an eligibility waiver**

Open Enrollment

Enrollment is only allowed during the first 31 days of the Fall Enrollment Period and the first 31 days of the Spring/Summer Enrollment Period. The only exceptions are:

1. Adding a new Dependent (within 31 days of marriage, birth or adoption);
2. Enrolling as a new or transfer Student (within 31 days of date of enrollment at the University).
3. Within 31 days of ineligibility under other Creditable Coverage and accepted and used up COBRA continuation coverage or similar state coverage if it was offered.

PREMIUMS PAID WITHIN OPEN ENROLLMENT PERIODS ARE NOT PRO-RATED

Effective and Termination Dates

The Policy on file at the university becomes effective 12:01 a.m. on August 15, 2009 and terminates 11:59 p.m. August 14, 2010. Coverage for newly enrolling students, spouses and dependent children will be effective on the Effective Date of the coverage period elected or the day after enrollment form and correct premium are received - whichever is later. Those students, spouses and dependent children covered under the 2008-09 Winthrop University Student Health Plan through the termination date of the 2008-09 Policy Year will have 31 days after the 2009-10 Policy effective date to re-enroll and maintain continuous coverage. Coverage will end for the Covered Person on the earliest of the date he or she becomes full time active duty in any Armed Forces*, or the end of the period for which premium was paid.

*Excludes Reserve or National Guard duty for training unless it exceeds 31 days. Submit proof of service to receive a pro-rata refund of premium for this period.

Pre-Existing Conditions

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: (a) the Covered Person has been covered under the Policyholder's prior Policy for 12 consecutive months immediately preceding the effective date of coverage under the current Policy; or (b) the Covered Person transferred from an institution of higher learning where he or she was previously covered under a sponsored University plan for 12 consecutive months and (1) he or she did not have a break in coverage of more than 31 days between the previous sponsored plan and enrolling in this Policy; and (2) the condition was covered under the previous plan and eligible for benefits under this Policy. Prior coverage under the previous sponsored plan of less than 12 months will be credited toward satisfying the Pre-existing Condition limitation; or (c) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under this Policy within 63 days of termination of prior Creditable Coverage; and the individual's most recent prior Creditable Coverage was under an employer group plan; and the individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her; and the individual is not eligible for coverage under any other group health plan, Medicare or Medicaid; and the individual does not have other health insurance.

Pre-Existing Condition means any Sickness, Injury or other medical or mental health condition existing within the six month period prior to the Covered Person's effective coverage date under the Policy for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or which was recommended for treatment by a doctor, or which was evaluated and/or treated by a health care provider; or a pregnancy existing on the Covered Person's effective date of Coverage under the Policy.

Additional Insurance Plan Benefits

Well Dental Benefits: Eligible Expenses paid at 100% of R&C

* Two annual Cleanings / Oral Evaluation

* Annual bitewing X-ray

Dental Treatment (For Injury to sound, natural teeth or removal of full bony impacted wisdom teeth ONLY) Maximum of \$1,000 per Accident or Sickness: after the deductible, 80% of Allowable Charge / 60% R&C

Chemotherapy / Radiation Therapy: after the deductible, 80% of Allowable Charge / 60% R&C

Maternity-Students and Spouses Only: Paid the same as any other Sickness.

Alcohol and Drug Abuse: Medically Necessary services to treat medical emergencies resulting from substance abuse. Definitive treatment shall be limited to care by a covered provider rendered under the Mental and Nervous Disorders Benefit.

Suicide, Attempted Suicide and Intentionally Inflicted Injury: Medically necessary inpatient and outpatient services to treat medical emergencies resulting from such actions will be covered as an Emergency Medical Condition. Medical Evacuation cases resulting from attempted suicide or intentionally inflicted Injury will be covered if otherwise qualified. Definitive treatment of any underlying mental health causal factors shall be covered under the Mental and Nervous Disorders benefits

Ambulance (air or ground) -Maximum of \$1,000 per emergent Sickness or Injury or doctor directed transfer between inpatient treatment facilities: after the deductible, 80% R&C

Orthopedic Braces, Orthopedic Appliances & Durable Medical Equipment: after the deductible, 80% Allowable Charge / 60% R&C

Consultant: after the deductible, \$15 copay per visit, 80% Allowable Charge / \$30 copay per visit, 60% R&C

Mammograms and Prostate Screening (available only with Student Health Services referral) See Policy for details.

Cervical Cytological Screening (available only at Student Health Services) See Policy for details.

Pharmacy services provided by informedRx, an SXC company: Present your insurance card at Participating Pharmacies to obtain prescriptions (see detailed benefit information at www.studentinsurance.com)

Wellness Benefit (Students Only): Maximum of \$300 per Policy Year, may include vaccines, physicals and other health prevention services:
Student Health Services - 100 % billed charge / No Deductible
Outside Student Health Services - after \$15 copay per visit / No Deductible, 100% of Allowable Charge / 80% R&C

Medical Evacuation: Maximum Benefits \$25,000 (see Policy for details)

Repatriation: Maximum Benefit \$25,000 (see Policy for details)

This plan also covers applicable Mandated Benefits as required by the State of South Carolina - Referrals Required

Student Assist: (see detailed information at www.studentinsurance.com) Emergency Medical transportation services. This is an assistance travel service and is separate from the Standard Security Life Insurance Company of New York Student Insurance Health Plan

Pre-Notification Requirement

1-888-722-1668

Required For Inpatient and Outpatient Procedures

It is the responsibility of the Covered Person to advise providers and ensure that pre-notification is accomplished prior to non-emergency health care being provided. Covered Persons should not agree to any admission, inpatient surgery or care, ambulatory or day surgery or treatment until benefits authorization is received from Pre-Notification.

WINTHROP UNIVERSITY PLAN SCHEDULE OF BENEFITS

BENEFIT CATEGORY	Health Care at Student Health Services	HEALTH CARE IN NETWORK	HEALTH CARE OUT OF NETWORK	
Policy Year Deductible per Person, including Newborns	None	Per Person - \$300 Per Family - \$800		
Maximum Benefit	\$100,000 per Accident or Sickness \$500,000 Aggregate per Lifetime (all conditions combined)			
To receive benefits, Students must visit Student Health Services first for treatment / referral. Exceptions are listed under Referrals				
INPATIENT with Health Center REFERRAL and Pre-Authorization Required	Hospital Room & Board	Not Applicable	80% Allowable Charge after deductible with \$200 copay per admission	60% R&C after deductible with \$300 copay per admission
	Intensive Care Services	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Hospital Miscellaneous	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Surgery-professional services	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Assistant Surgeon	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Anesthesia Services	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Registered Nurse	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Doctor's Visits (One visit per day)	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Consultant Doctor	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Physiotherapy (\$500 maximum per Policy Year for Inpatient and Outpatient expenses)	Not Applicable	80% Allowable Charge after deductible	60% after deductible or 80% after deductible if no PPO Provider is available
	Pre-Admission Testing	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Mental & Nervous Disorders	Not Applicable	Paid as any other Sickness	Paid as any other Sickness
	Newborn Nursery Care (\$1,000 max per child)	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
OUTPATIENT with Health Center REFERRAL Required	Surgery - professional services	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Day Surgery (Pre-Authorization Required) (\$5,000 Maximum per covered Accident or Sickness)	Not Applicable	80% Allowable Charge after deductible with \$100 copay per procedure	60% R&C after deductible with \$300 copay per procedure
	Anesthesia Services	Not Applicable	80% Allowable Charge after deductible	60% R&C after deductible
	Doctor's Visits - one visit per day	100% Eligible Expense with \$15 copay per visit	80% Allowable Charge after deductible with \$15 copay per visit	60% R&C after deductible with \$30 copay per visit
	Physiotherapy Services – When ordered by a doctor for treatment of a covered Sickness or Injury. Maximum of \$500 per Policy Year for Inpatient and Outpatient Expenses	Not Applicable	80% Allowable Charge after deductible	60% after deductible or 80% after deductible if no PPO provider is available
	Chiropractic Services-maximum of \$500 per Policy Year for Inpatient and Outpatient expense. For covered Injury or illness only	Not Applicable	80% Allowable Charge after deductible with \$15 copay per visit	60% R&C after deductible with \$30 copay per visit
	Diagnostic X-Ray Services	Not Applicable	80% Allowable Charge after deductible with \$15 copay per visit	60% R&C after deductible with \$30 copay per visit
	Laboratory Procedures	Not Applicable	80% Allowable Charge after deductible with \$15 copay per visit	60% R&C after deductible with \$30 copay per visit
	Tests and Procedures	Not Applicable	80% Allowable Charge after deductible with \$15 copay per visit	60% R&C after deductible with \$30 copay per visit
	Mental & Nervous Disorders	100% Eligible Expense with \$15 copay per visit	80% Allowable Charge after deductible with \$15 copay per visit	60% R&C after deductible with \$30 copay per visit
	Prescription Drugs maximum of \$1,000 per Policy Year (includes ADD and ADHD drugs). Each refill is limited to 30-day supply per month. However obtained, all prescription drugs are subject to the Prescription Drugs maximum. (Prescription Birth Control covered ONLY at SHS)	80 % of Eligible Expense, not subject to copay. Includes prescription birth control options	informedRx, an SXC company, participating pharmacies: 80% after a \$10 Generic copay/\$25 Brand Name copay per prescription or refill. Mandatory Generic-must use generic if authorized and available or be charged the brand name drug copay plus the difference between the brand name drug and the generic drug prescription.	
	Emergency Room Expense – for Emergency Medical Conditions only.	Not Applicable	80% after deductible with \$100 copay per visit (if not admitted)	80% after deductible with \$100 copay per visit (if not admitted)

Exclusions and Limitations

Except to the extent specifically allowed by this Plan as covered benefits, no benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Commission or attempt to commit a felony.
2. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro rata premium will be refunded upon request for such period not covered).
3. Participation in a riot or civil disorder or fighting (with the exception of self defense).
4. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; (c) while participating in any practice or conditioning program for such sport, contest or competition (but this exclusion does not apply to injuries sustained while participating in intramural, extramural or club sports program).
5. Treatment in Government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
6. Elective surgery and elective treatment or examination where no Injury or Sickness is involved except as specifically provided for under the Policy.
7. Preventive medicines unless specifically provided for in the Policy.
8. Expenses incurred for eyeglasses, contact lenses, hearing aids, or prescriptions or examinations for such except when due to a disease process, or as specifically provided elsewhere in the Policy.
9. Expenses incurred for radial keratotomy; and/or for the surgical correction of nearsightedness, astigmatism, or any other correction of vision due to a refractive problem.
10. Expenses incurred for any services rendered by a Covered Person's immediate family member.
11. Expenses incurred for a treatment, service or supply which is not Medically Necessary.
12. Charges in excess of Reasonable and Customary charges.
13. Serums unless specifically provided for in the Policy.
14. Mental health and substance abuse care services except as specifically provided for under the Policy.
15. Expenses incurred 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; or skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, or bungee jumping.
16. Expenses that may be covered by state or federal programs, such as items covered by Workers Compensation, Occupational Disease Law, Medicaid, or Medicare.
17. Expenses associated with cosmetic surgery, except for charges related to accidental Injury, corrective surgery for congenital anomalies; and/or reconstructive surgeries following a mastectomy.
18. Expenses incurred as a result of a suicide or an attempted suicide (including drug overdose) or self-inflicted injury except as specifically provided for under the Policy.
19. Expenses incurred for services and supplies related to nicotine addiction; biofeedback services and supplies related to biofeedback; circumcision; hirsutism; nonmalignant moles and lesions; patient controlled analgesia (PCA); pre-marital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; acne; acupuncture; allergy testing; alopecia; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery; sleep disorders including supplies, treatment, or testing related to sleep disorders; and gynecomastia.
20. Services for Injury or Sickness related in any way to employment.
21. Expenses incurred for Elective Surgery or Elective Treatment or abortion.
22. Expenses for organ transplants.
23. Expenses incurred for reproductive/infertility services including but not limited to: fertility tests; infertility drugs or artificial insemination agents; services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures include: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance reproductive abilities.
24. Expenses for procedures, treatment, drugs, devices, supplies or medical services that are experimental or investigational in nature.
25. Expenses for surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for under the Policy.
26. Expenses for services that are not provided by a legally licensed Doctor. These medical services and/or treatment must be within the scope of the Doctor's license.
27. Expenses incurred for hair transplants, hair pieces, or wigs.
28. Expenses incurred for services provided by a campus Student Health Service and normally provided as part of the student health fee by the Policyholder's Student Health Service facility or by healthcare providers employed by the Policyholder.
29. Expenses incurred for out-patient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference as a result of or related to distortion, misalignment, or subluxation of or in the vertebral column.
30. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
31. Expenses for hormone treatment or hormone therapy not related to the treatment of Sickness.

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.

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 this 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; or (c) a body organ or part would be seriously damaged; or (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.

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.

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.

Sickness means disease, illness or Complications of Pregnancy, 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.

All Sicknesses due to the same or a related cause are considered One Sickness.

PPO Providers

For services rendered in the State of South Carolina, Persons insured under this plan may choose to be treated within or outside of the Medcost PPO Network. For services rendered outside of the State of South Carolina, Persons insured under this plan may choose to be treated within or outside of the First Health PPO Network. Reimbursement rates will vary according to the source of care as described under the Plan Schedule of Benefits herein. Assignment of a Network Provider does not guarantee eligibility or right to student health benefits.

It is the Covered Person's responsibility to verify that a provider is a Participating Provider prior to services being rendered.

Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or the facility to which the Covered Person is referred is also a PPO provider.

www.studentinsurance.com / 1-888-722-1668

EXTENSION OF BENEFITS: 1. If a Covered Person is hospitalized on their termination date for a covered Injury or Sickness, eligible expenses for treatment of such Injury or Sickness will continue to be paid for 90 days so long as the Covered Person is hospitalized and the maximum benefits have not been paid. The total payment made for any covered condition, both before and after the termination date, will never exceed the maximum benefit. 2. If a Covered Person is undergoing outpatient treatment for an acute or emergency covered Injury or Sickness on the termination date, eligible expenses for treatment of such Injury or Sickness will be paid for that episode of acute or emergency care so long as the Injury or Sickness or treatment began prior to the termination date, but only while they are incurred during the 31 day period following such termination of insurance. The total payment made for any covered condition, both before and after the termination date, will never exceed the maximum benefit.