



CIIS
California Institute of Integral Studies

2007-2008
**Student
Injury
and
Sickness
Insurance
Plan**



underwritten by
**National Union Fire
Insurance Company of Pittsburgh, Pa.**
administrator policy number
AMH0062038

ATTENTION

Enroll online at: www.renstudent.com/ciis

A temporary ID Card is attached to this booklet. Please detach and retain for proof of coverage. A permanent ID card will be mailed to you after you have enrolled in the plan.

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ATTENTION

A temporary ID Card is attached to this booklet. Please detach and retain for proof of coverage. A permanent ID card will be mailed to you after you have enrolled in the plan. Covered Dependents may also use this card to obtain treatment. Only one permanent ID card will be mailed to you each school year.

Always carry your insurance identification card with you.

Also, there is a Quick Reference Guide at the back of this booklet. You should tear it out and keep it with you along with your ID card.

ELIGIBILITY

All Full-Time students (including Distance Learning courses for California residents only), as determined by CIIS, are eligible to enroll in this insurance plan. However, only students new for the Spring Term may enroll in the insurance for the Spring/Summer Term. Students have until September 11, 2007 for the Annual Term or January 29, 2008 for the Spring/Summer Term (Add/Drop Deadline) to attain Full-Time Status through the school.

Covered Students may also enroll their eligible dependents in the plan. An eligible dependent is the Covered Student's: 1) legal spouse; or 2) unmarried children under the age of 19 years (23 if a full-time student at an accredited school).

For a newly acquired dependent child, that child will be covered under the Policy for the first 31 days after:

1. birth of a newly born child; or
2. in the case of an adoptive child, the earlier of:
 - a) the effective date of adoption of the child; or
 - b) the date of placement of the child with the Covered Person for adoption.

Coverage for such child will be for Sickness or Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Benefits will be the same as any other covered person who is the child's parent.

The Covered Student will have the right to continue such coverage for the child beyond 31 days. To continue the coverage the Covered Student must, within 31 days after the birth, adoption or placement for adoption: 1) notify the Company in writing; and 2) pay the required additional premium for the continued coverage. If the Covered Student does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth, adoption or placement for adoption.

The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been and continue to be met. If and whenever 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.

TERMS OF COVERAGE

The Policy becomes effective at 12:01 a.m. on August 23, 2007. The individual Covered Person's coverage becomes effective at 12:01 a.m. on: 1) the beginning date of the applicable term if the student completes enrollment online **before** this date; or 2) the date immediately following the date on which the student completed enrollment online if online enrollment is completed **on** or **after** the beginning date of the applicable plan term in which the student is enrolling.

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TERMS OF COVERAGE (continued from page 1)

Coverage terminates at 12:01 a.m. on the earliest of the following dates:

1. The date the Policy is terminated by the Policyholder or the Company;
2. The last day of the Term of Coverage for which premium is paid;
3. The date a Covered Person enters full-time active military service;
4. The last day of the period through which premium has been paid, following the date a dependent ceases to be a dependent as described in this brochure.

	Effective Date	Termination Date	Enrollment Deadline
Annual	08/23/07	08/22/08	09/23/07
Spring/Summer	01/28/08	08/22/08	02/28/08

Please note online enrollment cannot be accepted after the Enrollment Deadline Dates listed. Newly acquired dependents (spouse and/or children) are not subject to the Enrollment Deadline Dates. However, enrollment for all newly acquired dependents (spouse and/or children) must be completed within 31 days of the attainment of such dependents. **Otherwise, enrollment cannot be accepted after the Enrollment Deadline Dates listed.**

In no event will dependent coverage extend beyond that of the covered student.

There is no continuation coverage for this plan for students and/or dependents who are no longer eligible.

Eligibility requirements must be met each time premium is paid to continue coverage.

COSTS OF COVERAGE

Deadline	Annual	Spring/Summer
	8/23/07 to 8/22/08 9/23/07	1/28/08 to 8/22/08 2/28/08
Student	\$ 983.00	\$ 639.00
Spouse	\$ 2,445.00	\$ 1,589.00
Each Child	\$ 1,370.00	\$ 873.00

REFUNDS

No premium refunds are permitted, except when a Covered Person enters full-time active military service, at which time a pro rata refund of premium paid will be made upon written request.

PREFERRED PROVIDER ORGANIZATION

Please read the following information so you will know from whom or what group of providers health care may be obtained.

This plan has incorporated into the coverage access to the First Health Network of Hospitals and Doctors. The coverage provides benefits nationwide for Eligible Expenses incurred at 90% of Allowable Charges when treated by network providers. Coverage provides benefits worldwide for Eligible Expenses incurred at 70% of Reasonable and Customary (R&C) charges when treated by non-network providers. However, if such treatment is received in a non-PPO facility due to an Emergency Medical Condition, benefits for Eligible Expenses are payable at the PPO level. For a complete listing of the PPO Hospital and Doctor facilities, call FHN at **1-800-226-5116** or access the FHN website at: www.myfirsthealth.com.



Please be aware that the Preferred Provider Organization (PPO) for this plan has changed. Before seeking treatment, make sure that your doctor is a member of the new network or you may have to pay a higher coinsurance.

If a Covered Person is being treated by a Preferred Provider for an acute, serious chronic condition, pregnancy, newborn, or a terminal illness, and the Provider's contract terminates with the PPO, the Covered Person may be eligible under certain conditions to continue treatment with the Provider at the PPO rate. Contact the claims administrator for details.

Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at that 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 facility to which he/she is referred is also a PPO provider. For instance, when a network provider refers a Covered Person to a lab for tests, he/she should be sure it is a network lab. Also, if a Covered Person has surgery, he/she should make sure the anesthetist is a network provider or he/she will be required to pay the 30% coinsurance.

EXCESS COVERAGE

This plan of insurance is secondary and provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any other valid and collectible insurance. If the Covered Person is covered by other valid and collectible insurance, all benefits payable by such insurance will be determined before benefits will be paid by this plan. This plan is the second payor to any other insurance having primary status. Benefits paid by this plan will not exceed: 1) any applicable plan maximums; and 2) 100% of the compensable expenses incurred when combined with benefits paid by any other valid and collectible insurance.

MEDICAL EVACUATION BENEFIT

When, as a result of an Injury or Sickness, the Covered Person is hospitalized for at least five (5) consecutive days, the Company will pay for evacuation to the Covered Person's home country or to a facility operated pursuant to the law of the Covered Person's home country for the care and treatment of injured or ill persons, or to another medical facility in the United States. Such action must be Medically Necessary and upon the recommendation of the attending Doctor and approved by the Company, or its authorized representative. The Company will pay the actual Eligible Expense incurred, but not to exceed the Maximum Aggregate Benefit of \$25,000. All transportation must be approved in advance by the Company or its authorized representative.

REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies while insured under this Policy, the Company will pay the actual expense incurred for preparation and transportation of the remains of the deceased's body to a designated facility in their home state, or in the case of international students to a designated facility in their home country (in accordance with the applicable international requirements), but not to exceed the Maximum Aggregate Benefit of \$25,000. This benefit is payable in addition to any other benefit of this Policy. Any expenses for repatriation require prior approval from the Company or its authorized representative.

STATE MANDATED BENEFITS

The State of California mandates coverage for the following: 1) equipment, supplies and outpatient self-management training for diabetes; 2) phenylketonuria (PKU), including enteral formulas and special food products that are part of a diet prescribed by a Doctor; 3) treatment of Severe Mental Illness; 4) anesthesia and facility charges for dental procedures under certain circumstances; 5) preventative care for children age 16 and under according to the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; 6) mammograms; 7) prostate, colorectal and cervical cancer screening and generally medically accepted cancer screening tests; 8) breast cancer screening, diagnosis, and treatment; 9) a second opinion requested by a Covered Person or Doctor; 10) participation in the Expanded Alpha Feto Protein (AFP) Program; 11) prosthetic devices to restore a method of speaking incidental to laryngectomy; 12) diagnosis, treatment and management of osteoporosis; 13) clinical trials for cancer; 14) AIDS vaccine; 15) reconstructive surgery under certain circumstances; 16) telemedicine medical services; 17) prescription contraceptive drugs or devices (if there is a prescription drug benefit); and 18) maternity services as provided by CA Insurance Code section 10123.87 (a). Please see the Policy on file with the Institute for further details.

EXCLUSIONS

This Policy does not cover or provide benefits for loss or expenses incurred:

1. as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth, as provided in the Policy;
2. for services normally provided without charge by the Institute's Health Service, infirmary or Hospital, or by health care providers employed by the Institute or services covered by the Student Health fee;
3. for eye examinations, eyeglasses, contact lenses, or prescription for such; radial keratotomy or laser surgery; or treatment for visual defects and problems. Visual defects means any physical defect of the eye which does or can impair normal vision apart from the disease process;
4. for hearing examinations or hearing aids; or other treatment for hearing defects and problems. Hearing defects means any physical defect of the ear which does or can impair normal hearing apart from the disease process;
5. 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;
6. for Injury or Sickness resulting from war or act of war, declared or undeclared;
7. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
8. 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;
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
10. for cosmetic surgery except as required to correct an Injury for which benefits are otherwise payable under the policy. Cosmetic surgery shall not include reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: a) improve function; or b) create a normal appearance, to the extent possible; or c) as specifically provided for in the Policy. It also shall not include breast reconstructive surgery after a mastectomy;
11. for preventive treatment or testing, except as specifically provided in the Policy;

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EXCLUSIONS (continued from page 5)

12. as a result of committing or attempting to commit a felony or participation in a riot or civil commotion;
13. for Elective Treatment or elective surgery;
14. for any services rendered by a Covered Person's immediate family member;
15. for a treatment, service or supply which is not Medically Necessary;
16. as a result of suicide or any attempt at suicide, including drug overdose, or intentionally self-inflicted Injury;
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; acupuncture; allergy, including allergy testing; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical correction thereof; family planning; 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; learning disabilities; nonmalignant warts, moles and lesions unless Medically Necessary; premarital examinations; sexual reassignment surgery; sleep disorders, including testing thereof; preventive medicines or vaccines, except where required for the treatment of Injury; smoking cessation; tubal ligation; vasectomy; weight reduction;
19. for routine physical examinations, except as specifically provided for in the Policy;
20. for addiction and co-dependency services and supplies related to nicotine addiction;
21. for bungee jumping;
22. for organ transplants;
23. for Injury resulting from the practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, club, professional and semi-professional sports; hang gliding; parasailing; sky diving; glider flying; sail planing; parachuting;
24. for Injury resulting from fighting, except in self-defense;
25. for treatment of obesity, except resulting from diabetes, regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs;
26. for the services of an assistant surgeon;
27. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational; and
28. for injections.

PRE-EXISTING CONDITION LIMITATION

Expenses incurred by a Covered Person as a result of a Pre-Existing Condition will not be considered Eligible Expenses for a period of six (6) months while covered under this Policy.

This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for six (6) consecutive months. Prior Creditable Coverage of less than six (6) months will be credited toward satisfying the Pre-Existing Condition limitation. This waiver of the Pre-Existing Condition limitation will apply only if the Covered Person becomes eligible and enrolls for coverage within 63 days of termination of his or her prior coverage.

Pre-Existing Conditions do not apply to:

1. a newborn Dependent child; or
2. 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 this Policy; or
3. pregnancy or complications of pregnancy.

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:

1. 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, coverage for onsite medical clinics, 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;
2. the federal Medicare Program pursuant to Title XVIII of the Social Security Act;

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PRE-EXISTING CONDITIONS (continued from page 7)

3. the Medicaid program pursuant to Title XIX of the Social Security Act;
4. any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care;
5. 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS));
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a state health benefits risk pool;
8. a health plan offered under 5 U.S.C.A., Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP));
9. a public health plan as defined by federal regulations authorized by Section 2701(c)(1)(l) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996;
10. a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e));
11. any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec.300gg(c)).

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the brochure.

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

Company means the National Union Fire Insurance Company of Pittsburgh, Pa.

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.

Doctor means: 1) legally qualified physician licensed by the state in which he or she practices; and 2) 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 3) 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: 1) not in excess of the Reasonable and Customary charges; or 2) not in excess of the charges that would have been made in the absence of this coverage; 3) is the negotiated rate, if any and 4) 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: 1) the Covered Person's life could be in serious jeopardy; 2) bodily functions would be seriously impaired; or 3) a body organ or part would be seriously damaged; or 4) serious disfigurement; or 5) serious jeopardy to the health of the fetus.

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SCHEDULE OF BENEFITS

The Company will pay the Eligible Expenses incurred for treatment of a covered Injury or Sickness, up to the limits stated below.

Lifetime Aggregate Maximum Benefit: \$75,000 per Injury or Sickness

Deductible: \$150 per Policy Year

The Covered Person is responsible for paying the deductible before the Company will begin paying benefits.

Eligible Expenses include the following:

INPATIENT

Hospital Room and Board (average semi-private room rate)	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Intensive Care Expense	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Hospital Miscellaneous when incurred during Hospital Confinement, including anesthesia, operating room, laboratory, x-rays including professional fees, oxygen, drugs, medicines and dressings	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Surgery	90% of Allowable Charges for PPO or 70% of R&C for non-PPO; up to a maximum of \$5,000
Anesthetist	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Pre-Admission Testing	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Private Duty Nurse	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Doctor Visits	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Mental and Nervous Disorders	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Physiotherapy	90% of Allowable Charges for PPO or 70% of R&C for non-PPO

OUTPATIENT

Doctor Visits	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Physiotherapy (includes Medically Necessary chiropractic treatment and massage therapy when referred by the attending Doctor)	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Emergency Room	90% of Allowable Charges for PPO or 70% of R&C (90% for an Emergency Medical Condition) for non-PPO; up to a maximum of \$400
Surgery	90% of Allowable Charges for PPO or 70% of R&C for non-PPO; up to a maximum of \$5,000
Day Surgery Miscellaneous related to scheduled surgery performed in a hospital, including: operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines and supplies. R&C charges for Day Surgery Miscellaneous based on the Outpatient Surgical Facility Charge Index	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Anesthetist	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Laboratory and X-Ray	90% of Allowable Charges for PPO or 70% of R&C for non-PPO; up to a maximum of \$950
Radiation Therapy/Chemotherapy	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Tests and Procedures	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Mental and Nervous Disorders*	90% of Allowable Charges for PPO or 70% of R&C for non-PPO; up to a maximum of \$100 per visit; up to a maximum of 50 visits (25 for dependents) per plan year
Alcohol/Drug	90% of Allowable Charges for PPO or 70% of R&C for non-PPO; up to a maximum of \$1,000

OTHER

Ambulance	90% of R&C
Durable Medical Equipment	90% of R&C
Dental (for Injury to sound, natural teeth only)	90% of R&C
Consultant	90% of Allowable Charges for PPO or 70% of R&C for non-PPO
Prescription Drugs (including prescription contraceptives)	After a \$15 copay per prescription, 90% of R&C; up to a maximum of \$700 per plan year
Elective Abortion	90% of Allowable Charges for PPO or 70% of R&C for non-PPO; up to a maximum of \$500
Pregnancy/Maternity	Same as any other Sickness
Well-Baby Care	Same as any other Sickness

* Treatment of Severe Mental Illness is paid the same as any other condition. Please see the definition on page 14.

DEFINITIONS (continued from page 9)

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: 1) 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; 2) 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; 3) 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; 4) 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 5) 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:

1. it provides inpatient services for the care and treatment of injured and sick people; and
2. it provides room and board services and nursing services 24 hours a day; and
3. it has established facilities for diagnosis and major surgery; and
4. it is supervised by a Doctor; and
5. it is run as a Hospital under the laws of the jurisdiction in which it is located; and

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DEFINITIONS (continued from page 12)

6. it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

The term Hospital includes: 1) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; 2) an ambulatory surgical center or ambulatory medical center; 3) a mental health hospital if supervised and licensed by the Department of Mental Health; and 4) 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.

Hospital does not include a place run mainly: 1) as a convalescent home; 2) as a nursing or rest home; or 3) as a place for custodial or educational care;

Hospital Confined or Hospital Confinement means a stay of at least 18 consecutive hours for which a room and board charge is made.

Injury means bodily injury due to an accident which: 1) results solely, directly and independently of disease, bodily infirmity or any other causes; 2) occurs after the Covered Person's effective date of coverage; and 3) 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.

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:

1. it is provided only as a convenience to the Covered Person or provider; or
2. it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or
3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. it is Experimental/Investigational or for research purposes; or
5. could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
6. 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
7. involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or

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DEFINITIONS (continued from page 13)

8. 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.

Mental or Nervous Disorder(s) means any nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder (other than those conditions deemed severe mental illness) on the date the medical care or treatment is rendered to a Covered Person.

Policyholder means California Institute of Integral Studies.

Pre-Existing Condition means a Sickness or Injury for which medical care, treatment, diagnosis or advice, including use of prescription drugs, was received or recommended within the six (6) months prior to 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: 1) the actual charge; 2) the charge usually made for a covered service by the provider who furnishes it; 3) the negotiated rate, if any; and 4) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. Reasonable and Customary charges also mean the percentile of the payment system in effect on the Effective Date.

Severe Mental Illness means 1) schizophrenia; 2) schizoaffective disorder; 3) bipolar disorder (manic-depressive illness); 4) major depressive disorders; 5) panic disorder; 6) obsessive-compulsive disorder; 7) pervasive developmental disorder or autism; 8) anorexia nervosa; 9) bulimia nervosa; and 10) Treatment of a child who: a) is suffering from one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and b) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

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.

CLAIM PROCEDURE

1. Obtain treatment from the nearest Doctor or Hospital. The Covered Person may choose any Doctor or Hospital, but using the Doctors and Hospitals available through the First Health Network (PPO) may decrease costs. For a complete listing of the PPO Doctors or Hospital facilities, call FHN at **1-800-226-5116** or access the internet website **www.myfirsthealth.com**
2. If a Covered Person goes to a Doctor's office or to the Hospital, the Covered Person should present his/her insurance identification card. Dependents covered under the plan do not receive separate ID cards and may use the covered student's ID card to obtain treatment. If the Doctor or Hospital needs to verify coverage, have them call Personal Insurance Administrators, Inc. at **1-800-468-4343**.

The Covered Person should carry his/her insurance ID card at all times.

3. Complete a claim form, which is available online at **www.renstudent.com/ciis**. The claim form must be complete and signed. Attach all itemized medical and Hospital bills.
4. Send claim form, bills and all other expenses to Personal Insurance Administrators, Inc. at:

Personal Insurance Administrators, Inc.

P.O. Box 6040

Agoura Hills, CA 91376-6040

Toll Free 1-800-468-4343

www.piaclaims.com

5. If a Covered Person has questions about the status of a claim after it has been submitted, please call Personal Insurance Administrators, Inc. at **1-800-468-4343**.

All hospital and medical bills must be submitted for payment within 90 days after the first date of treatment. Failure to furnish this information within the 90-day period shall not invalidate nor reduce the Covered Person's claim if it was not reasonably possible to file the claim within this time, provided that the claim is submitted as soon as is reasonably possible. In no event, except in the absence of legal capacity, will a claim be honored later than one (1) year from the date of last medical treatment.

Covered Persons have the right to file a written complaint and obtain an expedited review if health care services have been improperly denied, modified, or delayed.

Always keep a copy of all documents submitted for claims.

CERTIFICATION OF QUALIFYING HEALTH PLAN COVERAGE

If a Covered Person is no longer eligible to be insured under the plan, the Covered Person should request a Certification of Qualifying Health Plan Coverage from Renaissance Agencies, Inc. This request can be made by phone or in writing. This request must include the name of the school and the name of each person who is no longer eligible to be insured under the plan.

AUTHORIZED REPRESENTATION

In accordance with state and federal rules and regulations, we will not disclose individual information without authorization. This includes disclosures to family members for insured individuals who have reached the age of majority.

If the Covered Person would like to authorize an additional party to act as a personal representative for matters pertaining to this insurance plan, we must have an Authorization Form on file. To request a form, please contact Renaissance Agencies, Inc. at the address below or complete a form via the internet at: www.renstudent.com.

SUMMARY OF PRIVACY POLICY

We strongly believe in maintaining the confidentiality of the personal information we obtain and/or receive about Covered Persons and we are committed to protecting the privacy of Covered Persons. We do not disclose any nonpublic information about Covered Persons to anyone, except as permitted or required by law. We do not sell or otherwise disclose Covered Person's personal information to anyone for purposes unrelated to our products and services. We maintain physical, electronic and procedural safeguards that comply with federal and state regulations to protect information about Covered Persons from unauthorized disclosure. We may disclose any information we believe necessary to conduct our business as is legally required. Covered Persons have the right to access, review and correct all personal information collected. Covered Persons may review this Privacy Policy in its entirety, or the Privacy Policies of other entities servicing the Policy, by writing to the address or visiting the website shown below. Covered Persons may also submit a request, in writing, to review your information at the address below.

Renaissance Agencies, Inc.
Attention Privacy Manager
P.O. Box 2300
Santa Monica, CA 90407-2300
Phone: (800) 537-1777
Facsimile: (310) 394-0142
Website: www.renstudent.com

NATIONAL UNION FIRE INSURANCE
COMPANY OF PITTSBURGH, PA.

ADMINISTRATOR POLICY NUMBER
AMH0062038

2007-2008 CALIFORNIA INSTITUTE OF INTEGRAL STUDIES VOLUNTARY ENROLLMENT FORM

1. PLEASE PRINT CLEARLY

STUDENT'S LAST NAME			
STUDENT'S FIRST NAME			INITIAL
STUDENT'S PERMANENT MAILING ADDRESS—STREET			APT/BOX #
CITY		STATE	ZIP
STUDENT'S PHONE NUMBER		STUDENT'S DATE OF BIRTH (MM/DD/YY)	
STUDENT'S SOCIAL SECURITY NO.		STUDENT ID NUMBER	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	STUDENT'S E-MAIL ADDRESS		

2. MARK THE TERM YOU HAVE SELECTED.

	ANNUAL 8/23/07 to 8/22/08 9/23/07	SPRING/SUMMER 1/28/08 to 8/22/08 2/28/08
STUDENT ONLY	<input type="checkbox"/> \$ 983.00	<input type="checkbox"/> \$ 639.00
SPOUSE	<input type="checkbox"/> \$ 2,445.00	<input type="checkbox"/> \$ 1,589.00
EACH CHILD	<input type="checkbox"/> \$ 1,370.00	<input type="checkbox"/> \$ 873.00

PLEASE NOTE PREMIUM RATES CANNOT BE PRORATED.

SPOUSE AND CHILD RATES ARE IN ADDITION TO THE STUDENT ONLY RATE AND CANNOT BE PURCHASED SEPARATELY.

3. COMPLETE REVERSE SIDE FOR DEPENDENT COVERAGE

**4. MAKE CHECK OR MONEY ORDER PAYABLE TO:
NUFIC**

SEE REVERSE SIDE FOR CREDIT CARD PAYMENT

PAYMENTS CANNOT BE ACCEPTED OVER THE PHONE OR BY FAX

5. RETURN PAYMENT WITH ENROLLMENT FORM TO:

RENAISSANCE AGENCIES, INC.
P.O. BOX 2300
SANTA MONICA, CA 90407-2300

MUST BE POSTMARKED BY THE DEADLINE DATE LISTED

6. STUDENT MUST SIGN FORM BELOW.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF THIS COVERAGE.

STUDENT'S SIGNATURE _____

DATE _____

**7. PLEASE DETACH AND RETAIN THE ID CARD ON THE BACK COVER.
COVERED DEPENDENTS MAY ALSO USE THIS CARD TO OBTAIN TREATMENT.**

**CALIFORNIA INSTITUTE OF INTEGRAL STUDIES
STUDENT INSURANCE PLAN
QUICK REFERENCE GUIDE**

*this page contains useful information
detach and carry with you at all times along with your ID Card*

Insurance Company:

National Union Fire Insurance Company of Pittsburgh, Pa.
70 Pine Street
New York, NY 10270

Administrator Policy Number:

AMH0062038

For questions regarding benefits or claims:

Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
1-800-468-4343
www.piaclaims.com

For questions regarding eligibility or enrollment:

Renaissance Agencies, Inc.
P.O. Box 2300
Santa Monica, CA 90407-2300
1-800-537-1777

To enroll online:

www.renstudent.com/ciis

To download brochures, claim forms or ID cards, access the internet website:

www.renstudent.com/ciis

FREQUENTLY ASKED QUESTIONS (FAQS)

Why do I need health insurance?

Medical costs can be overwhelming and are rising continuously. Without health insurance, a student can go into debt with excessive medical bills that may hinder his or her academic career.

Am I eligible to enroll in this insurance plan?

All Full-Time students (including Distance Learning courses for California residents only), as determined by CIIS, are eligible to enroll in this insurance plan. However, only students new for the Spring Term may enroll in the insurance for the Spring/Summer Term. Students have until September 11, 2007 for the Annual Term or January 29, 2008 for the Spring/Summer Term (Add/Drop Deadline) to attain Full-Time Status through the school.

How do I enroll in this insurance plan?

1. You may enroll online at: www.renstudent.com/ciis by the Deadline Date.
2. You may also enroll by completing the enrollment form attached to this brochure. Answer all questions, indicating the term in which you are enrolling. Please note: even if you are enrolling after the effective date of the term, you must still pay the total premium amount for that term. Premiums cannot be prorated.

Submit the completed form, along with the proper premium payment (including payment for any eligible dependents you are enrolling), to Renaissance Agencies, Inc. at the address above (must be postmarked by the Enrollment Deadline Date).

Please note: dependents must enroll for the same period of coverage as the covered student. Please see pages 1 and 2 of this brochure for dependent eligibility/enrollment requirements.

When does my coverage begin?

Please see the Terms of Coverage section on page 1 and 2 for further details.

(continued)

LIST DEPENDENTS TO BE INSURED BELOW.

DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE STUDENT IS ALSO INSURED UNDER THIS PLAN.

	LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER	SEX
SPOUSE	_____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD	_____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD	_____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD	_____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
STUDENT'S SIGNATURE	_____				DATE SIGNED	_____

CHARGE CARD AUTHORIZATION — CREDIT CARD PAYMENTS CANNOT BE ACCEPTED OVER THE PHONE OR BY FAX
WILL APPEAR AS "STUDENT HEALTH INSURANCE, RENAISSANCE AGENCIES" ON YOUR CREDIT CARD BILL

MasterCard # or Visa # _____ Expiration Date _____ Charge This Amount _____
Name of Cardholder _____ Signature of Cardholder _____

FAQ'S (continued)

When does my coverage end?

Coverage terminates at 12:01 a.m. on the termination date of the applicable term for which premium is paid. Please see the Terms of Coverage section on page 1 and 2 for further details. Please note the company does not send termination/renewal notices to students/dependents when their coverage terminates.

If a student withdraws from school for any reason, coverage under the insurance plan will remain in effect until 12:01 a.m. on the termination date of the applicable term for which premium was paid. Coverage cannot be cancelled and no premium refunds are permitted for any reason, except when the student enters full-time active military service, in which case a pro-rata refund will be made upon request.

Where do I get an ID card?

A temporary ID Card is attached to this booklet. Please detach and retain for proof of coverage. A permanent ID card will be mailed to you after you have enrolled in the plan. Covered Dependents may also use this card to obtain treatment. Only one permanent ID card will be mailed to you each school year.

Is vision or dental coverage provided under this plan?

Though treatment for an Injury to teeth is covered under the plan as described herein, general vision and dental benefits are not provided by this plan. Please contact Renaissance Agencies, Inc. at 1-800-537-1777 or access the website www.renstudent.com/dental for details on other options.

What do I do if I get sick or injured?

1. Obtain treatment from the nearest Doctor or Hospital. You may choose any Doctor or Hospital, but using the Doctors and hospitals available through the PPO network may decrease your costs. For a complete listing of the PPO Doctors or Hospital facilities, call FHN at **1-800-226-5116** or access the internet website www.myfirsthealth.com.
2. If you go to a Doctor's office or to the Hospital, be sure to show your insurance ID card (attached to this brochure). Dependents covered under the plan do not receive separate ID cards and may use the Covered Student's ID card to obtain Treatment. If the Doctor or hospital needs to verify coverage for you or your dependents, have them call Personal Insurance Administrators, Inc. at **1-800-468-4343**.

Carry your insurance ID card with you at all times.

How do I get my medical bills paid?

1. After you receive treatment, complete the insurance company claim form. Claim forms are available at: www.renstudent.com/ciis.
2. If you have any other expenses such as medicines, x-rays or laboratory charges, be sure to attach these bills to the claim form.
3. Send your claim form and all other bills to Personal Insurance Administrators, Inc. at the address below. Try to have all itemized bills attached to the same claim form.

Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040

4. If you have questions about the status of your claim after it has been submitted, please call Personal Insurance Administrators, Inc. at **1-800-468-4343**.

IMPORTANT NOTICE

The Policy is Non-Renewable One-Year Term Insurance. Similar coverage may be purchased for the following academic year. It is the Covered Person's responsibility to obtain coverage the following year in order to maintain continuity of coverage. Covered Persons who have not received information regarding a subsequent program prior to the Policy's Termination Date should inquire regarding such coverage with the school or Renaissance Agencies, Inc.

A temporary ID Card is below. Please detach and retain for proof of coverage. A permanent ID card will be mailed to you after you have enrolled in the plan. Covered Dependents may also use this card to obtain treatment. Only one permanent ID card will be mailed to you each school year.

Covered Persons should carry an insurance ID card at all times.

ID CARD—PLEASE DETACH AND RETAIN FOR PROOF OF COVERAGE

Underwritten by:
National Union Fire Insurance Company of Pittsburgh, Pa.
Administrator Policy Number AMH0062038

Covered Person _____

**CALIFORNIA INSTITUTE OF INTEGRAL STUDIES
2007-2008 STUDENT HEALTH INSURANCE PLAN**

Both the effective and termination dates of coverage are subject to verification by the Company.
(see reverse side)



Underwritten by:

National Union Fire Insurance Company of Pittsburgh, Pa.,
with its principal place of business in New York, NY
Administrator Policy Number: AMH0062038

For questions regarding benefits or claims:

Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
1-800-468-4343
www.piaclaims.com

For questions regarding eligibility or enrollment:

Renaissance Agencies, Inc.
P.O. Box 2300
Santa Monica, CA 90407-2300
1-800-537-1777

**To download brochures, claim forms or ID cards,
access the internet website:**

www.renstudent.com/ciis

Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series S30494NUFIC-CA. The Policy on file at the University may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this document and the Policy, the Policy shall govern.

Underwriter Reference No. CAS9710548

For questions regarding claims and coverage, contact:
PERSONAL INSURANCE ADMINISTRATORS, INC.

P.O. Box 6040
Agoura Hills, CA 91376-6040
Toll Free 1-800-468-4343
www.piaclaims.com

Note: Benefits are subject to payment of appropriate premium and verification of eligibility.



For information on PPO Providers,
access www.myfirsthealth.com
or call 1-800-226-5116