

SERFF Tracking Number: CCGH-125860743 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 40649
Company Tracking Number:
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student Blanket
Project Name/Number: /

Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: Student Blanket SERFF Tr Num: CCGH-125860743 State: ArkansasLH
TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed State Tr Num: 40649
Sub-TOI: H04.001 Student Co Tr Num: State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Jennifer Bonafilia Disposition Date: 10/29/2008
Date Submitted: 10/22/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: Group Market Size: Large
Overall Rate Impact: Group Market Type: Blanket
Filing Status Changed: 10/29/2008
State Status Changed: 10/29/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

Connecticut General Life Insurance Company acquired the Student Blanket business provided by Great-West Life & Annuity Insurance Company, on April 1, 2008. Under the terms of the purchase agreement, CIGNA is required to migrate all existing Great-West Student Blanket policyholders to Connecticut General Life Insurance Company policies.

To retain the Great-West's Student Blanket policyholders, Connecticut General Life Insurance Company would like to be able to offer them student blanket policies that duplicate their existing Great-West student blanket policies. Connecticut General Life Insurance Company would also like to be able to offer future customers the same student blanket policies

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previously offered by Great-West. Accordingly, we are submitting for your approval Connecticut General Life Insurance Company student blanket policy forms that duplicate the Great-West student blanket policy forms previously approved by your office.

Upon approval, these forms will be issued as part of the entire policy, to educational organizations that renew or purchase student blanket accident and sickness insurance coverage for students and/or other persons of similar description and their eligible dependents.

Variable material in the policy is shown in brackets “[]”, and an explanation of variables is enclosed with this letter.

Please note that these forms contain nonmaterial changes in the form of text formatting, page layout, corrections to typos and other minor wording changes to clarify intent.

For your convenience, we have included a listing of the approved Great-West policy forms. It includes the Form Number, Form Type, Approval Date and State/SERFF Filing Identifier (when available).

These forms have been written in readable language and are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, positioning and format. However, printing standards will never be less than that required under your law.

We appreciate you taking the time to review this submission and trust that you will find everything in order. If you should have any questions or require additional information, please do not hesitate to e-mail me at jennifer.bonafilia@cigna.com or 860.226.8054

Thank you,

Jennifer Bonafilia

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Company and Contact

Filing Contact Information

Jennifer Bonafilia, Compliance Specialist jennifer.bonafilia@cigna.com
 900 Cottage Grove Road (860) 226-8054 [Phone]
 Hartford, CT 06152 (860) 226-5400[FAX]

Filing Company Information

Connecticut General Life Insurance Company CoCode: 62308 State of Domicile: Connecticut
 900 Cottage Grove Road Group Code: 901 Company Type:
 Hartford, CT 06152 Group Name: State ID Number:
 (860) 226-5209 ext. [Phone] FEIN Number: 06-0303370

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--|---------|----------------|---------------|
| Connecticut General Life Insurance Company | \$50.00 | 10/22/2008 | 23394148 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 10/29/2008 | 10/29/2008 |

Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---------------------------|----------------|------------|----------------|--------------------|------------|----------------|
| Status | Created By | Created On | Date Submitted | Responded By | Created On | Date Submitted |
| Pending Industry Response | Rosalind Minor | 10/24/2008 | 10/24/2008 | Jennifer Bonafilia | 10/29/2008 | 10/29/2008 |

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Disposition

Disposition Date: 10/29/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Item Type | Item Name | Item Status | Public Access |
|----------------------------|------------------------------------|--------------------|----------------------|
| Supporting Document | Certification/Notice | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | List of Forms | Approved-Closed | Yes |
| Supporting Document | Variable Memo | Approved-Closed | Yes |
| Supporting Document | Offer Form | Approved-Closed | Yes |
| Form (revised) | Blanket Accident & Sickness Policy | Approved-Closed | Yes |
| Form | Blanket Accident & Sickness Policy | Replaced | Yes |

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/24/2008

Submitted Date 10/24/2008

Respond By Date

Dear Jennifer Bonafilia,

This will acknowledge receipt of the captioned filing.

Objection 1

- Blanket Accident & Sickness Policy (Form)

Comment: There is an exclusion for illness or bodily infirmity resulting from an act of terrorism. Our Department will not approve exclusions for terrorism in life or accident and health contracts. The Department's position is that losses due to acts of terrorism are so inherent to the risk purported to be assumed in the general coverage of the contract, than any exclusion of such losses would be inconsistent with the general coverage of the contract. In that regard, please refer to ACA 23-79-110(a)(2).

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 10/29/2008

Submitted Date 10/29/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: The word "terrorism" has been removed from exclusion #22 on form BLK97-EX(AR)(04-06), and from exclusion #4 on form BLK97-DC(AR)(04-06), and from exclusion #4 on form BLK97-ADD(AR)(04-06).

Please let me know if you have any other questions.

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Thank you.

Related Objection 1

Applies To:

- Blanket Accident & Sickness Policy (Form)

Comment:

There is an exclusion for illness or bodily infirmity resulting from an act of terrorism. Our Department will not approve exclusions for terrorism in life or accident and health contracts. The Department's position is that losses due to acts of terrorism are so inherent to the risk purported to be assumed in the general coverage of the contract, than any exclusion of such losses would be inconsistent with the general coverage of the contract. In that regard, please refer to ACA 23-79-110(a)(2).

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|------------------|----------------|--|----------------|----------------------|-------------------|---------------------|
| Blanket Accident & Sickness Policy | BLK97(AR) | (04-06) | Policy/Contract/Fraternal Certificate | Initial | | | PolicyAR.pdf |
| Previous Version | | | | | | | |
| <i>Blanket Accident & Sickness Policy</i> | <i>BLK97(AR)</i> | <i>(04-06)</i> | <i>Policy/Contract/Fraternal Certificate</i> | <i>Initial</i> | | | <i>PolicyAR.pdf</i> |

No Rate/Rule Schedule items changed.

Sincerely,
 Jennifer Bonafilia

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Form Schedule

Lead Form Number: BLK97(AR)(04-06)

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------|------------------|-------------|---|---------|----------------------|-------------|--------------|
| Approved-Closed | BLK97(AR)(04-06) | Policy/Cont | Blanket Accident & Fraternal Sicknss Policy Certificate | Initial | | | PolicyAR.pdf |

CONNECTICUT GENERAL

LIFE INSURANCE COMPANY
900 Cottage Grove Road
Hartford, Connecticut 06152
(herein called "the Company")

[Deductible] [Copayment][Plus] Plan

[INTERNATIONAL] [OUTBOUND] [DOMESTIC] BLANKET ACCIDENT AND SICKNESS POLICY

the Company issues to

Any Educational Organization]
(herein, the "Policyholder")

Policy Number: BLK-4554-[XXX] [(Reissued)]
(herein, the "Policy")

Policy Year: [November 1 through the following October 31]

Effective Date: [November 1, 2002]

Place of Delivery: State of []

This Policy is governed by the laws of the State of [] and other applicable laws and regulations.

In consideration of the Policyholder's application and timely payment of premium, the Company will pay applicable benefits to eligible insureds. Such payment is subject to all provisions of this Policy.

This Policy is non-participating.

Signed at the office of CONNECTICUT GENERAL LIFE INSURANCE COMPANY on this [1st] day of [February] [2003].

[Secretary]

President

| |
|------------------------|
| POLICY SCHEDULE |
|------------------------|

A. The [International] [Outbound] [Domestic] Blanket Accident and Sickness Policy number BLK-4554-[XXX] [(Reissued)], as issued to the Policyholder, contains a number of optional insurance benefits. However, only the insurance benefit(s) selected by the Policyholder, as described in B. below, will apply to and be in effect for the Policyholder and any person insured under such Policyholder's insurance Policy.

B. Based on the Policyholder's selection, made at the time of the application, only those insurance benefit(s) identified below with a "Yes" notation, accompanied by a signature of the Company's authorized personnel, is/are applicable to the Policyholder.

| | | | |
|-------|--|----------|-------------------------|
| _____ | Major Medical Benefits: <input type="checkbox"/> Student Only <input type="checkbox"/> Student and Spouse <input type="checkbox"/> Student, Spouse and Child(ren) | [Yes/No] | Signature: _____ |
|-------|--|----------|-------------------------|

| | | | |
|---------|--|----------|---------------------------|
| [_____] | Optional Accidental Death and Dismemberment (AD&D) (Student Only Coverage) | [Yes/No] | Signature: _____] |
|---------|--|----------|---------------------------|

| | | | |
|---------|--|----------|---------------------------|
| [_____] | Dental Care Benefits <input type="checkbox"/> Student Only <input type="checkbox"/> Student and Spouse <input type="checkbox"/> Student, Spouse, Child(ren) | [Yes/No] | Signature: _____] |
|---------|--|----------|---------------------------|

| | | | |
|----------|--|----------|---------------------------|
| [_____] | Extended Coverage for: <input type="checkbox"/> Student Only <input type="checkbox"/> Student and Spouse <input type="checkbox"/> Student, Spouse, Child(ren) | [Yes/No] | Signature: _____] |
|----------|--|----------|---------------------------|

The above list of insurance benefit(s) identified as applicable to the Policyholder may later be added or deleted by an amendment issued to the Policy.

[Any and all references to "Dependent" apply only if Dependent coverage is elected.]

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ELIGIBILITY, EFFECTIVE AND TERMINATION DATES OF INDIVIDUAL COVERAGE

ELIGIBILITY

Eligible Student means any [international] [and practical training][outbound] [domestic] student, [and] [visiting faculty,] [scholar,] [or] [other persons of similar description] of the Policyholder who [meets all of the following]:

- 1.] is enrolled and actively engaged full-time [, as defined by the Policyholder in accordance with applicable United States law,] in educational activities.
- 2.] is temporarily outside his/her home country or country of regular domicile as a non-resident alien, or a non-domiciled United States citizen with dual citizenship, [in the United States].
- 3.] has a current passport and [applicable] current [student] [B,] [F-1,] [J-1,] [or] [M-1] visa or other non-immigrant visa which allows the individual to enroll in a course of study (non-domiciled United States citizen – passport only).]
- 4.] maintains non-immigrant status under the applicable visa type [according to applicable United States law].

[For purposes of Item 1. above,] eligible students taking a term or semester break (herein referred to as “term break”), annually, in accordance with school policy and while keeping coverage in force are considered Eligible Students engaged in full-time educational activities.

[For schools with a two-semester term system, summer break is the designated term break.] [For schools with a [trimester] [or] [quarter] term system, any [trimester] [or] [quarter] can be taken as the term break, provided only one [trimester] [or] [quarter] is taken per academic calendar year.]

[The following do not count toward fulfilling the full-time status Eligibility requirement:

- 1.] [home study.]
- 2.] [correspondence courses.]
- 3.] [internet courses.]
- 4.] [television courses.]

[International students who have applied for permanent residency in the U.S. in accordance with federal law in effect at the time of enrollment, are not Eligible Students.]

Eligible Dependent means any dependent of an Eligible Student who meets all of the following:

1. is the Eligible Student's lawful spouse or unmarried Child (under age [19] and dependent upon the Eligible Student or the student's spouse for the Child's main support and care);
2. resides with the Eligible Student; [and]
3. is enrolled for coverage under the Policy at the same time the Eligible Student enrolls[.] [.]
4. has a current passport and visa (non-domiciled United States citizen – passport only) [; and]]
5. is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien, or a non-domiciled United States citizen with dual citizenship, [in the United States] [.]

Continued Eligibility for Disabled, Unmarried Child: The Insured Student's disabled, unmarried dependent Child may continue to be an Eligible Dependent Child beyond age [19] if all of the following, additional conditions are met:

1. The Child became disabled before reaching age [19];
2. The Child is incapable of self-sustaining employment because of developmental disability or physical handicap and is chiefly dependent upon the Insured Student for support and maintenance;
3. The student remains insured under this Policy;
4. The Child's premiums, if any, continue to be paid;
5. First proof of incapacity must be given to the Company (at our expense) as soon as possible after the Child reaches age [19]. The Company's approval of such statement is required for the Child to continue eligibility; and
6. The Insured Student provides proof satisfactory to the Company of the Child's disability and dependent status when the Company requests it.

“Child” means an Eligible Student's natural Child; step-Child; adopted Child or a Child Placed For Adoption which means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of the adoption of such Child; the Child's placement with the Eligible Student is considered terminated upon the termination of such legal obligation. When a petition for adoption of a Child is filed by the Insured Individual, dependent coverage for that Child will begin on the date of the filing if such individual applies for coverage within 60 days of the date of the filing. For a newborn adopted Child, dependent coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the Child.

Newborn Infants - Sick Baby Care: A newborn Child of an Insured Student will automatically be an Insured Individual for 90 days from the moment of birth **only** for Covered Expenses incurred which are due directly to Injury or Bodily Infirmary, premature birth, or a congenital condition which exists at birth. In order to continue the coverage of a newborn Child beyond the 90th day following date of birth: (1) notice of the birth of the Child must be provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, must be received by the Company. If (1) and (2) above are not satisfied, coverage of a newborn Child, including any Continuation of Benefits, will terminate 90 days from the date of birth.

Newborn Infants - Well Baby Care: A newborn Child of an Insured Student will be an Insured Individual from the moment of birth if: (1) notice of the birth of the Child is provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, is received by the Company. Covered expenses for the newborn Child will include: (a) Hospital room and board (or nursery) charges, (b) routine Doctor visits while Hospital confined; and (c) circumcision while Hospital confined. Such Covered Expenses for Well Baby Care are payable until the earlier of the date the Mother is discharged from the Hospital or the date the Child is ≥ 5 days old.

EFFECTIVE DATE OF INDIVIDUAL COVERAGE

For Eligible Students:

Provided the Policyholder has paid the required premium for the specific Eligible Student in accordance with the Policy provisions, coverage for that Eligible Student who has enrolled in the plan will be effective:

1. on the first day of the school term for which coverage is applied for if the Eligible Student became an Eligible Student on the first day of the school term and applies within the first 60 days of the school term;
2. on the first day of becoming an Eligible Student if such day is after the first day of the school term, and enrollment is made within 60 days of becoming an Eligible Student;
- [3.] [for an Eligible Student who is eligible for Extended Coverage, 30 days prior to the first day of the school term if the Eligible Student applies for coverage within the first 60 days of the school term;]
4. on the first day an Eligible Student suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
5. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Student or after an Eligible Student suffers an involuntary loss of other coverage; or
6. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

[Extended Coverage means additional days of coverage that are available to a newly enrolled Eligible Student [and his or her Eligible Dependents] who arrive in the [United States] [country in which the student is attending school] prior to the commencement of the student's studies.] Subject to timely application and payment of premium as described above, Extended Coverage will be effective 30 days prior to the first day of the school term. Upon the Eligible Student's graduation or completion of an educational program and in preparation for the resulting departure from the [United States][country in which the student is attending school], coverage for the student [and his or her covered Dependents] will terminate 30 days following graduation or completion of an educational program, provided the student [and his or her covered Dependents] remain[s] in the [United States] [country in which such individual is attending school] during that 30-day period].

[An Eligible student who is covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:

1. the request is made prior to the termination of Extended Coverage; and
2. the premium is promptly paid for the additional 30 days of coverage; and
3. the Insured Student and covered Dependents, if any, remain in the [United States][the country in which the student attended school].]

For Eligible Dependents:

Coverage for an Eligible Dependent of an Eligible Student, who has enrolled in the plan and for whom the Policyholder has paid the required premium, will be effective:

1. the date the Eligible Student's coverage begins with respect to each Eligible Dependent the student has at time of his/her enrollment;
- [2.] [For an Eligible Student's Eligible Dependent under Extended Coverage, 30 days prior to the first day of the school term if the Eligible Student applies within the first 60 days of the school term. See "Extended Coverage" provision for more information.]
3. the date of birth of a natural child, if enrollment is made within 90 days of birth;
4. the date of birth of a Child Placed For Adoption or for which a petition for adoption has been filed, if enrollment is made within 60 days birth;
5. the date a petition for adoption is filed for the adoption of a Child, if enrollment is made within 60 days of such filing.
6. on the first day of the first month following the dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured Student is covered under the Policy;
- [7.] on the first day of the first month following the date the dependent first meets the definition of "Eligible Dependent" if such dependent did not qualify at the time the Insured Student was enrolled under the Policy. Enrollment must be made within 31 days of becoming eligible;]
- [8.] on the first day an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
- [9.] on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Dependent or after an Eligible Dependent suffers an involuntary loss of other coverage; or
- [10.] under special circumstances, the effective date determined by the Company_for all similarly situated eligible persons.

Dependent coverage cannot become effective prior to the Effective Date of Coverage of the Eligible Student.

TERMINATION DATE OF INDIVIDUAL COVERAGE

Coverage for an Insured Individual will automatically terminate on the earliest of the following dates:

1. the date the Policy terminates;
2. the last day of the period for which premium has been timely paid according to Policy provisions;
3. the date the Insured Individual is no longer eligible for coverage; [or]
- [4. For an Insured Individual under Extended Coverage, as described in the "Extended Coverage" provision;]
5. the date requested by the Insured Individual and approved by the Policyholder in writing that is no sooner than 5 days after the date the Company (or its authorized administrator) receives written notice. Any unearned premium will be returned, but returned premium will only be for the number of full months remaining in the unexpired term of coverage; [or][.]
- [6. the date the Insured Individual departs [the United States] for the individual's home country or country of regular domicile.]

PREMIUM

Premium Due Dates: The first premium is due on the effective date. [Future premiums are due each school term on the first day of the school term.] [Future premiums are due each [month] on the [first day] of the [month].] The Policyholder shall submit to the Company for each period of coverage a roster of and premiums for the Insured Individuals.

Grace Period: If premium is not paid within 30 days after the due date, the Policyholder shall have 31 days of grace to pay the premium. The policy shall remain in force during such time. If the premium is not paid within this 31 day period, the Policy will cease to be in effect and coverage will terminate retroactively to the day before the due date.

Premium Rates: The Company may change the premium rates on or after the first Policy anniversary, but not more often than once in any 6 (six) month period. Notwithstanding, the Company may change the premium rate on any date the Policy is amended.

The required premium rates under the Policy at its effective date are:

[Major Medical Benefits [(includes Dental Care)]

| | | |
|-----------------------------|----------------|--------------|
| Eligible Student | \$ [] [*] | [per month] |
| Eligible Student and Spouse | \$ [] [*] | [per month] |
| Each Eligible Child | \$ [] [*] | [per month]] |

[* Includes [\$4.00] per student per month for administration of extended coverage.]

[Dental Care Benefits

| | | |
|-----------------------------|-----------|--------------|
| Eligible Student | \$() | [per month] |
| Eligible Student and Spouse | \$() | [per month] |
| Each Eligible Child | \$() | [per month]] |

[Accidental Death and Dismemberment Coverage

| | |
|------------------|--|
| Eligible Student | \$ [0.00] per \$1,000 of Maximum Amount per month] |
|------------------|--|

[MAJOR MEDICAL BENEFITS

Each Insured Student covered under the [International] [Outbound][Domestic] Policy has a Major Medical Benefit maximum [per Accident or Sickness] (*remove for high deductible*) of [\$75,000]. [Each Eligible Dependent covered under the [International] [Outbound] [Domestic] Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$50,000].] [However, in no event will the benefit maximum for all Accidents and Sickness exceed [\$50,000] (*remove for high deductible*) in any consecutive 12-month period per Insured Individual.]

DEDUCTIBLE

Covered Expenses will be paid at [100%] after satisfying the following Deductible amounts:

1. With respect to the Insured Student[:] (*delete colon for outbound plans*)
 - [a.] If the educational institution at which the student attends has a Student Health Center:
 - i. there will be [no] [\$15.00] Deductible for Covered Expenses from the Student Health Center;
 - ii. there will be a [\$20.00] Deductible per Accident or Sickness if the Insured Student is referred outside the Student Health Center by a Student Health Center Physician;
 - iii. there will be a [\$50.00] Deductible per Accident or Sickness if the Insured Student does not visit the Student Health Center first for diagnosis and treatment of a covered Injury or Bodily Infirmary.]
(*Use for International or domestic with regular deductible plan*)
 - [a.] There will be a [\$50.00] Deductible per Accident or Sickness.] (*Use with Outbound plans*)
 - [b.] If the educational institution at which the student attends does not have a Student Health Center, there will be a [\$50.00] Deductible per Accident or Sickness.] (*Use for International or domestic with regular deductible plan*)
 - [a.] There will be no Deductible for Covered Expenses from the Student Health Center.
 - b. There will be a [\$500.00] Deductible for Covered Expenses not incurred at a Student Health Center in any consecutive 12 month period.]. (*Use for high deductible plan*)
- [2.] With respect to the Insured Individual who is the Eligible Dependent, there will be a [\$50.00] Deductible per Accident or Sickness.] (*Use with regular deductible plan*)
- [2.] With respect to the Insured Individual who is the Eligible Dependent, there will be a [\$500.00] Deductible per Accident or Sickness not to exceed [\$500.00] in any consecutive 12 month period.]. (*Use with high deductible plan*)
3. With respect to any Insured Individual, there will be an additional [\$50.00] Deductible per Sickness before a benefit is payable for Covered Expenses which are incurred for visits to a Hospital emergency room. Such Deductible shall not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.

[Maximum Family Deductible

In no event will the Family Deductible amount for Covered Expenses exceed [\$1,000.00] in any consecutive 12 month period for an Insured Student and Eligible Dependents.]

INSURING CLAUSE

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable for a Covered Expense if:

1. the Deductible requirement, if any, is met;
2. the expense is incurred due to a covered Injury or Bodily Infirmary;
3. the Insured Individual has not exceeded the Policy's Major Medical Benefits maximums.]

[MAJOR MEDICAL BENEFITS

Each Insured Student covered under the [International] [Outbound][Domestic] Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$75,000]. [Each Eligible Dependent covered under the [International] [Outbound] [Domestic] Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$50,000].] [However, in no event will the benefit maximum for all Accidents and Sickness exceed [\$50,000] in any consecutive 12-month period per Insured Individual.]

COPAYMENT BENEFIT SCHEDULE

Benefits for Covered Expenses will be paid as follows:

1. For charges of a Doctor, Covered Expenses will be paid at:
 - a. [100%], [with][without] application of a [\$15.00] Copayment for services provided at a Student Health Center.
 - b. [100%], after the Insured Individual pays a [\$25.00] Copayment per visit for services provided by a Participating Provider.
 - c. [80%], after the Insured Individual pays a [\$35.00] Copayment per visit for services provided by a provider who is not a Participating Provider.
2. For charges incurred at a Hospital (includes outpatient and inpatient services), Covered Expenses will be paid at:
 - a. [100%], after the Insured Individual pays a [\$50.00] Copayment per inpatient Hospital admission or outpatient visit for services provided by a Participating Provider.
 - b. [80%], after the Insured Individual pays a [\$100.00] Copayment per inpatient Hospital admission or outpatient visit for services provided by a provider who is not a Participating Provider.
3. For charges incurred at a Hospital for emergency room care, Covered Expenses will be paid at:
 - a. [100%], after the Insured Individual pays[:]
 - a [\$50.00] Copayment per visit for services provided by a Participating Provider [for treatment of an Accident].
 - [- a [\$100.00]** Copayment per visit for services provided by a Participating Provider for treatment of a Sickness.]
 - b. [80%]*, after the Insured Individual pays[:]
 - a [\$125.00] Copayment per visit for services provided by a provider who is not a Participating Provider [for treatment of an Accident].
 - [- a [\$175.00]** Copayment per visit for services provided by a provider who is not a Participating Provider for treatment of a Sickness.]

* If it was not reasonably possible to get to a Participating Provider for Emergency Care, the Participating Provider level of payment will be payable.

** This Copayment will not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.

Benefits will be paid at these levels unless stated otherwise in the Covered Expense section or Exceptions and Exclusions section. The Insured Individual will not be reimbursed for a Copayment.

Emergency means an Injury or Emergency Medical Condition that reasonably requires an Insured Individual to seek immediate medical care within [48] hours after the Injury or the onset of the Emergency Medical Condition.

Emergency Care means covered services furnished or required to screen and stabilize an Emergency Medical Condition, which may include but shall not be limited to, health care services that are provided in a Hospital's emergency facility.

Emergency Medical Condition means the sudden, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required. Emergency Medical Conditions may include, but are not limited to:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. inadequately controlled pain; or
5. with respect to a pregnant woman having contractions:
 - a. inadequate time to effect a safe transfer to another Hospital before delivery; or
 - b. a transfer to another Hospital may pose a threat to the health or safety of the woman or unborn Child.

Benefits For Services of a Participating Provider

The Policy provides different levels of benefits and copayments depending on whether or not the Insured Individual uses the services of a Participating Provider. The Insured Individual is free, however, to use the provider of his or her choice. If the Insured Individual selects a Participating Provider, the Policy may pay benefits, if any, to the provider of service.

[Out-of-Pocket Expense Maximum

When [\$2,000] [\$3,000] in Out-of-Pocket Expenses has been paid by any Insured Individual during a calendar year, the [80%] level of benefit payments for services will automatically increase to 100% for any additional eligible Covered Expense incurred by that same Insured Individual during the remainder of that calendar year and Copayment charges will no longer apply.

An Out-of-Pocket Expense is the [20%] share of any otherwise eligible (Reasonable and Customary) expense and Copayment amounts that an Insured Individual pays.]

INSURING CLAUSE

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable for a Covered Expense if:

- (1) the Copayment amount, if any, is met;
- (2) the expense is incurred due to a covered Injury or Bodily Infirmary;
- (3) the Insured Individual has not exceeded the Policy's Major Medical Benefit maximums.]

COVERED EXPENSES

Covered Expense means only the expense actually incurred for medical care, treatment, services, and supplies by an Insured Individual which are Medically Necessary and meet the following conditions:

1. are prescribed by a Doctor for the therapeutic treatment of a covered Injury or Bodily Infirmity;
2. are not excluded by any provisions contained in the Policy; and
3. are not more than the Reasonable and Customary charges (as defined by the Policy) [with respect to out of network charges].

To determine if medical care and supplies and the expense charged are Reasonable and Customary, the Company will consider the medical care or supplies usually given and the fees usually charged for a like Injury or Bodily Infirmity in that Area.

[If the Insured Individual uses a Participating Provider, Covered Expense means the agreed upon rate set between the Company and such provider for medical services which meet all of the above standards.]

The Company will consider each Covered Expense to be incurred on the date the medical care or supply is received. Covered Expenses under the Policy are limited to the following:

1. charges for diagnosis and treatment by a Doctor, registered nurse (not a Close Relative of or same legal residence as the Insured Individual).
2. charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges.
3. charges by a Hospital for outpatient medical care received on an outpatient basis and outpatient medical supplies which are used on the premises of a Hospital.
4. charges for home health care performed by a licensed home health agency when prescribed by a Doctor in lieu of Hospital services, provided the Hospital services would have been Covered Expenses under the Policy.
5. charges for laboratory, x-ray, and other diagnostic examinations.
6. charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay up to [100%] of charges for such drugs used on an inpatient basis [or dispensed by a Student Health Center] and [50%] of charges for such drugs [not dispensed by a Student Health Center Physician and] which are used for outpatient treatment.
- [[7.] charges for prescription oral contraceptives dispensed by a Student Health Center or a licensed pharmacist; the Policy will pay up to [50%.]
- [[8.] charges for prescription contraceptive devices.]
9. charges for emergency professional ambulance service by ground or air to a Hospital [up to a maximum benefit of [\$500.00]] (see Medical Evacuation Benefit below for air service to an Insured Individual's home country).

10. charges for the following types of orthopedic or prosthetic devices or Hospital equipment:
- a. man-made limbs or eyes for the replacing of natural limbs or eyes;
 - b. casts, splints or crutches;
 - c. purchase of a truss or brace;
 - d. oxygen and rental of equipment for giving oxygen;
 - e. rental of a wheelchair or Hospital bed;
 - f. rental of dialysis equipment and supplies;
 - g. colostomy bags and ureterostomy bags; and
 - h. two external post-operative breast prostheses.
- The Policy will not cover rental charges for equipment in excess of the purchase price of the equipment.

[11.] charges for one routine baseline or screening mammogram in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation.

[[12.] charges for one routine pap smear in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation.]

- [13.] charges for colorectal cancer screening examinations and laboratory tests for an Insured Individual:
- a. who is 50 years of age or older;
 - b. who is less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society guidelines;
 - c. regardless of age, if the person is experiencing symptoms of colon cancer.

[[14.] charges for an elective abortion to a maximum benefit of [\$500] per occurrence.]

- [15.] charges for anesthesia and facility charges in connection with dental procedures performed in a Hospital for an Insured Person who is:
- a. under 7 years of age, if 2 Dentists certify that the Child has a significantly complex dental condition; or
 - b. any age, with a serious medical or physical condition; or
 - c. any age, if a Physician determines that the person has a significant behavioral problem.
- This does not include coverage of the dental procedure. [If the dental procedure is an eligible covered dental expense, then it will be covered under the Policy's Dental Care Benefit.]

[16.] charges for treatment of loss or impairment of speech or hearing, when performed by a licensed speech pathologist or audiologist. This does not include coverage of hearing instruments or devices. The maximum Benefit is [\$500] in any consecutive 12-month period. The maximum benefit per visit after satisfaction of the applicable [Copayment][Deductible] is [\$50] for the first visit and [\$25] thereafter. Charges in excess of these maximums shall not be included as Covered Expenses under the Policy.

Physiotherapy Expenses: Covered Expenses for Physiotherapy (as defined below) which are incurred while not confined in a Hospital and which are billed by a Doctor or physiotherapist shall not exceed the maximum amounts shown below. Charges in excess of these maximums shall not be included as Covered Expenses under the Policy.

The maximum Physiotherapy Benefit is [\$500] in any consecutive 12-month period. The maximum benefit per visit after satisfaction of the applicable [Copayment][Deductible] is [\$50] for the first visit and [\$25] thereafter.

"Physiotherapy," under the Policy, means treatment of Bodily Infirmary or Injury by the use of physical means including, but not limited to, air, heat, light, water, electricity, massage, manipulation, acupuncture or active exercise.

Pregnancy Expenses: Covered Expenses for pregnancy are payable on the same basis as Covered Expenses for any other Bodily Infirmary [with respect to an Insured Student or eligible spouse. No benefits are payable for any expenses which relate to the pregnancy of an eligible Child].

Pregnancy coverage shall also include post-delivery inpatient Hospital care for a mother and her newly born Child in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists which is ≥ 48 hours following a vaginal delivery, or ≥ 96 hours following a caesarean section. A decision to shorten the length of stay may be made by the attending Physician in consultation with the mother.

Post-Mastectomy Coverage: Coverage of a Medically Necessary mastectomy will also include coverage of the following:

1. physical complications during any stage of the mastectomy, including lymphedemas;
2. reconstruction of the breast;
3. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
4. two external breast prostheses.

Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

Inherited Metabolic Diseases: Benefits for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas for use in the treatment of phenylketonuria (PKU) will be considered a Covered Expense provided:

1. such food products are prescribed as medically necessary for the therapeutic treatment of PKU; and
2. the products are administered under the direction of a physician; and
3. the cost of such products exceeds $\geq \$2,400$ per year.

Benefits are subject to deductibles, coinsurance, copayments and maximums on the same basis as other similar Benefits under the Plan.

In Vitro Fertilization: Coverage will be provided for in vitro fertilization subject to the following conditions:

1. The insured female's oocytes must be fertilized with the sperm of her spouse;
2. (a) The Insured Student and his/her spouse have had a history of unexplained infertility of at least 2 years; or
(b) the infertility is associated with one or more of the following medical conditions:
 - i. Endometriosis;
 - ii. Exposure in utero to Diethylstilbestrol (DES);
 - iii. Blockage or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - iv. Abnormal male factors contributing to the infertility; and
3. The insured female has been unable to obtain successful pregnancy through a less costly infertility treatment covered by this policy.

The in vitro fertilization procedures must be performed at a medical facility licensed or certified by the Arkansas Department of Health as an in vitro fertilization clinic. If no such facility is licensed or certified in Arkansas or no such licensing program is operational, then coverage will be extended for any procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Cyropreservation (the procedure whereby embryos are frozen for later implantation) is an eligible expense within these in vitro fertilization benefits.

A pre-existing condition limitation of 12 months applies for these in vitro fertilization Benefits. This in vitro fertilization Benefit is subject to a lifetime maximum of $\geq \$15,000$.

Child Health Supervision Services: Coverage will be provided to dependent Children for "Child Health Supervision Services" from birth through 18 years of age at the following intervals:

20 visits will be included at approximately the following age intervals:

| | |
|-----------|----------|
| birth | 3 years |
| 2 weeks | 4 years |
| 2 months | 5 years |
| 4 months | 6 years |
| 6 months | 8 years |
| 9 months | 10 years |
| 12 months | 12 years |
| 15 months | 14 years |
| 18 months | 16 years |
| 2 years | 18 years |

"Child Health Supervision Services" means the periodic review of a Child's physical and emotional health provided by or under the supervision of a single Physician, during the course of one visit, including medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests, all in keeping with prevailing medical standards.

Coverage for immunization services is not subject to deductibles, coinsurance and Benefit Maximums. All other children's preventive health care services are subject to the same deductibles, coinsurance and Benefit maximums as other similar coverage in the Plan.

[Musculoskeletal Disorders Benefit: Benefits for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder will be considered a Covered Expense.

Benefits will be payable for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology on the same basis as any other musculoskeletal disorder in the body whether prescribed or administered by a Physician or Dentist.]

[Hospice Care Benefit: Charges for hospice care when prescribed by a Doctor in lieu of Hospital services, provided the Hospital services would have been Covered Expenses under the Policy, and subject to the following:

- the Insured Individual's must Physician recommend in writing on or before hospice care is started
- the Insured Individual must elect (in writing to Us) to follow the Physician's proposed treatment plan;
- such care must be administered by a licensed Hospice Care Facility;
- coverage is limited to a maximum of 6 months, with an additional 6 months of care in cases where the patient is facing imminent death or is entering remission, if certified in writing by the attending Physician.

Coverage under this provision ends if the Insured Individual elects (in writing) to discontinue Hospice care.

Hospice Care Benefits are not payable for:

- services provided by persons who do not regularly charge for their services;
- counseling which is not provided as part of the Hospice care plan;
- services provided by homemakers, caretakers and the like;
- funeral expense;
- treatment intended to cure the terminal illness.]

[Mental and Nervous Disorders, Alcoholism, Drug Dependency Coverage: Covered Expenses are payable for treatment of Injury or Bodily Infirmity from a Mental or Nervous Disorder, alcoholism or drug dependency, up to (a) an aggregate limit of [30] days of inpatient care in any consecutive 12 month period payable after any applicable [Deductible] [Copayment], and (b) outpatient treatment up to a benefit limit of [10] outpatient visits in any consecutive 12 month period, payable after any applicable [Deductible] [Copayment].

Interscholastic and Intercollegiate Sports Benefit: Benefits will be payable up to a maximum benefit of [\$25,000] per Accident arising out of practice for or participation in interscholastic or intercollegiate sports.

Medical Evacuation Benefit: Subject to prior approval from the Company or its authorized representative, as an additional benefit, the Policy will cover up to a maximum benefit of [\$50,000] of reasonable charges for air evacuation of an injured or sick Insured Individual [and a Health Care Provider or Escort if directed by the attending Doctor,] to the individual's [Home City] [home country or country of regular domicile], provided air evacuation:

1. is upon the attending Doctor's written certification;
2. results from a covered Injury or Bodily Infirmary; and
3. does not occur prior to the benefit approval.]

[“**Home City**” means the location within the United States where the Insured Individual intends to reside following medical evacuation.]

Repatriation Benefit: Subject to prior approval from the Company or its authorized representative, as an additional benefit, the Policy will cover up to a maximum benefit of [\$25,000], in the aggregate, reasonable expenses that are incurred in connection with the preparation and transportation of the body of a deceased Insured Individual to the individual's place of residence [within the United States where the Insured Individual is to be buried] [in the individual's home country]. This benefit does not include transportation expenses of any person accompanying the body. Prior approval from the Company is required for this benefit.]

Continuation Benefits: Covered Expenses incurred, while Hospital Confined, will be payable up to a maximum benefit of [\$5,000 or 13 weeks], whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's Insurance terminates. Benefits payable under this provision will terminate if an Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for medical care, treatment, supplies, or services not listed in the Covered Expense section;
- [2.] for medical care, treatment, supplies, or services for the Insured Individual in his/her home country or country of regular domicile; [except the Policy will cover Accident or Sickness for Outbound students up to a maximum benefit of [\$5,000] in any consecutive 12 month period, if the Insured Individual is returning to the United States due to the Accident or Sickness and the Accident occurred or Sickness commenced while the Insured Individual was insured under this Policy;]
- [3.] due to a pre-existing Injury or Bodily Infirmary or complication thereof. A pre-existing Injury or Bodily Infirmary is one where the Insured Individual: (a) has consulted a Doctor; (b) had medicine prescribed; or (c) is receiving or has received medical care for that Injury or Bodily Infirmary in the [6] months prior to the Insured Individual's Effective Date of Coverage under the Policy.

However, benefits will be payable for a pre-existing Injury or Bodily Infirmary after the Insured Individual's coverage has been in force for [12] consecutive months.

Modification to Pre-Existing Exclusion: The Policy will not impose pre-existing limitations on an Eligible Student or Eligible Dependent who enrolls for coverage as a Federally Eligible Individual. If an Eligible Student has a dependent that does not meet the Federally Eligible Individual definition, the Eligible Dependent will be subject to the pre-existing limitations as defined in the Policy.

The Policy will not impose pre-existing limitations on a Child who was covered by Creditable Coverage within 31 days of birth, adoption or Placement for Adoption, provided the Child has not subsequently been without Creditable Coverage for more than [62] days.

- [4.] for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, [abortion (except spontaneous and non-elective abortion),] circumcision (except as covered under the Newborn Infants - Well Baby Care provision), learning disabilities, immunizations, obesity, allergy tests, vitamins, and antitoxins;
- [5.] for routine physical or health examinations, except as provided in the Covered Expenses section;
- [6.] for any care in connection with the teeth, gums, jaw, or structures directly supporting the teeth; myofacial pain; or temporomandibular joint dysfunction, except the Policy will cover injury to natural teeth resulting from an Injury up to a maximum benefit of [\$100] per tooth [and an overall maximum benefit of [\$500]] per Accident;
- [7.] in excess of the Reasonable and Customary charge;
- [8.] for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from:
 - a. an Injury;
 - b. a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or
 - c. a mastectomy (refer to the Post-Mastectomy Coverage provision);
- [9.] for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
- [10.] for hearing aids, eye glasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery;

- [11.] for Injury or Bodily Infirmary if covered to any extent under: any occupational benefit plan; Worker's Compensation or similar law; medical payments under individual automobile insurance (except for no-fault auto insurance);
- [12.] [for birth control, including surgical procedures and devices;]
[for birth control devices and surgical procedures;]
- [13.] for Injury arising out of practice for or participation in professional sports;
- [14.] for medical care, treatment, supplies or services in excess of [\$25,000] per Accident arising out of practice for or participation in interscholastic or intercollegiate sports;
- [15.] for medical care, treatment, services, and supplies for which no charge is made or no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
- [16.] for intentionally self-inflicted Injury or Bodily Infirmary, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmary resulting from taking part in the commission of an assault or felony;
- [17.] for diagnosis, treatment, and all other care related to infertility, except as provided in the Covered Expenses section under the In Vitro Fertilization benefit Provision;
- [18.] Transcutaneous Electrical Nerve Stimulation (TENS) units;
- [19.] for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
- [20.] for Injury or Bodily Infirmary from a Mental or Nervous Disorder, alcoholism or drug dependency; except as listed in the Covered Expense section;
- [21.] for Injury or Bodily Infirmary resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license;
- [22.] for Injury or Bodily Infirmary resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
- [23.] for medical care, treatment, services, or supplies normally given without charge and provided by employees or Doctors employed by, under contract with, or retained by the Policyholder;
- [24.] for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy.

DEFINITIONS - Major Medical Benefits

Unless separately defined herein, wherever used in the Policy:

1. **Accident** means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a unforeseen force or event to that Insured Individual and independent of any other such force or event.
2. **Average Semiprivate Charge** means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.
3. **Bodily Infirmary** means a Medical Condition of an Insured Individual caused by, arising out of, resulting from or the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual.
4. **Close Relative** means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.
- [[5.] **Copayment** means that portion of a Covered Expense an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion.]
- [6.] **Covered Expense** – see Covered Expense Section of the Major Medical Benefits section of the Policy.
- [7.] **Creditable Coverage** means any of the following coverage that an Insured Individual had prior to enrollment under the Policy:
 - a. an employee group health plan;
 - b. health insurance coverage, individual or group, including coverage through a Health Maintenance Organization (HMO);
 - c. Medicare;
 - d. Medicaid;
 - e. TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families;
 - f. a medical care program of the Indian Health Service or of a tribal organization;
 - g. a state health risk pool;
 - h. a health plan offered under the Federal Employee Health Benefits Program;
 - i. a public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government or a foreign country, that provides health coverage to individuals who are enrolled in the plan;
 - j. a health benefit plan established by the Peace Corps Act;
 - k. a State Children's Health Insurance Program (S-CHIP).

Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under this Policy to group coverage by another plan. Coverage provided by this Policy is not considered Creditable Coverage by this or other student health policies. Certificates of Creditable Coverage will be issued to individuals terminating student status and remaining in the United States as set forth in the federal Health Insurance Portability and Accountability Act (HIPAA).

Days of Creditable Coverage that occur before a Significant Break in coverage do not count towards satisfaction of the pre-existing limitation. A Significant Break in Coverage means a period of 63 days during all of which the individual does not have Creditable Coverage.

[8.] **Deductible** means the dollar amount, specified in the Policy, of a Covered Expense which must be incurred as an out-of-pocket expense by each Insured Individual per Accident or Sickness before benefits are payable under the Policy.

[9.] **Doctor or Physician** means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual. It will also include any other licensed practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which benefits are provided under the Policy.

[10.] **Federally Eligible Individual** means an individual who meets all of the following:

- a. the individual has at least 18 months of Creditable Coverage as of the date on which the individual seeks coverage under the Policy
- b. the individual's most recent prior Creditable Coverage was under one of the following types of plans or an insurance plan offered in connection with any of these plans:
 1. an employee group health plan;
 2. a governmental plan; or
 3. a church plan;
- c. the individual is not eligible for coverage under another group health plan, Medicare or Medicaid;
- d. the individual does not have other health insurance coverage;
- e. the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and
- f. if the individual has the option to continue coverage under a COBRA continuation or similar State program, such coverage was elected and exhausted.

[11.] **Hospital** means only such a place that meets all of the following conditions:

- a. operates as a Hospital pursuant to law for the care and treatment of sick or injured individuals;
- b. has permanent and full-time care for bed patients;
- c. has a staff of one or more licensed Physicians available at all times;
- d. provides 24-hour a day care by registered nurses on duty or call;
- e. has surgical facilities; and
- f. is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a Hospital used as such.

Hospital also means a "free standing surgical center" that meets all of the following standards:

- a. is a licensed public or private place;
- b. has an organized medical staff of Doctors;
- c. has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care; and
- d. has R.N. services when a patient is in the facility.

Hospital also means such place operated mainly to treat a Mental or Nervous Disorder if it meets the standards below:

- a. is a Hospital, psychiatric Hospital or outpatient psychiatric center licensed by the Arkansas Health Department; or
- b. is a Community Mental Health Center certified by the Arkansas Department of Human Services, Division of Mental Health Services.

[12.] **Hospital Admission** means a single period of Hospital confinement or outpatient care for one or more causes.

- [13.] **Injury** means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual.
- [14.] **Insured Individual:** means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements.
- [15.] **Insured Student** means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
- [16.] **Intensive Care Unit** means a unit exclusively reserved for critically and seriously sick or injured patients requiring constant audio-visual observation, as prescribed by the attending Doctor, which provides room and board, trained and qualified personnel whose duties are primarily confined to such unit, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the Hospital's facilities.
- [17.] **Medical Condition** means any bodily or mental disease, illness or Injury requiring treatment by a Doctor.
- [18.] **Medically Necessary** means only care and treatment the Company determines meets all of the following conditions:
- a. the care and treatment is Appropriate, given the symptoms and is consistent with the diagnosis, if any. **"Appropriate"** means that the type, level and length of service and setting are needed to provide safe and adequate care and treatment;
 - b. it is rendered in accordance with generally accepted medical practice and professionally recognized standards;
 - c. it is not treatment that is generally regarded as experimental or unproven; and
 - d. it is specifically allowed by the licensing statutes which apply to the provider who renders the service.
- [19.] **Mental or Nervous Disorder** means neurosis, psychoneurosis, psychosis, or mental disease or disorder of any kind resulting from any cause including, but in no way limited to, biological cause.
- [[20.] **Participating Provider** means a Doctor or a Hospital that agrees to provide Medically Necessary care and treatment at set rates.]
- [21.] **Policy** means the Policy including all amendments, riders and endorsements.
- [22.] **Policyholder** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.
- [23.] **Reasonable and Customary** means, with regard to charges for medical services or supplies, the lowest of:
- a. the usual charge by the provider for the same or similar medical services or supplies;
 - b. the usual charges of most providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies; or
 - c. the actual charge for the services or supplies.
- "Area"** means the location where the medical care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of medical care or supplies.

- [24.] **Sickness** means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from or the cause of one period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. "One Period" commences with the onset of the initial (or only) Bodily Infirmary that occurred during the Sickness, and ends when the Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmary that occurred during that Sickness for ninety (90) consecutive days.
- [25.] **Student Health Center** means an ambulatory care facility affiliated or contracted with the Policyholder that at a minimum maintains a staff consisting of a nurse director/nurse practitioner, staff nurses and a staff physician or an arrangement with a physician to perform office visits.][**Student Health Center** [means][also includes] [a designated Take Care Health Center or other similar facility specified by the educational institution if such institution does not have a designated Student Health Center.]

COORDINATION OF BENEFITS

If this is not the Insured Individual's only plan coverage, the benefits payable under this Policy, and any other group plan for the Allowable Expenses incurred during any Benefit Determination Period will be coordinated so that the combined benefits paid or provided by all plans will not exceed 100% of such Allowable Expenses.

The Insured Individual must inform the Company if he/she has other coverage (for example, through a spouse's or parent's employer); and give consent to the release of information so that this provision may be used. The Insured Individual should first file his/her claim with the primary plan (as determined below). When the claim is paid, the Insured Individual should send a copy of the charges and a copy of the Explanation of Benefits Statement from the first plan to the secondary plan (as determined below). This will accelerate the processing of a claim.

One Plan will be determined to be primary (using the rules below). The primary plan pays its full benefits first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

A plan is primary when:

1. the plan does not have a COB provision;
2. the plan designates itself as an "excess" or "always secondary" plan; or
3. if both plans have a COB provision and, under the rules below, it is determined to be primary.

When both plans have a COB provision, the order in which the plans provide benefits is determined using the first of the following rules which applies:

1. Principal Covered Person/dependent. The plan that covers the person as a Principal Covered Person is primary. If an Insured Individual is also covered by Medicare, the plan covering the person as a Principal Covered Person is primary, the plan covering the person as a dependent of a Principal Covered Person is secondary, and then Medicare.
2. Dependent Children.
 - a. If the parents are not separated or divorced, the plan that covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan that covered the parent longer is primary. If the other plan does not have the "birthday rule", the rule in the other plan will determine the primary plan.
 - b. If the parents are separated or divorced, the plan which covers the natural parent with custody is primary; followed by the plan which covers the step-parent who has married the natural parent with custody; and finally, the plan which covers the natural parent without custody.

However, if the court decrees one of the parents responsible for health care expenses, the plan that covers that parent is primary.

If the decree names the parent other than the natural parent with custody, the Company must be notified and have actual knowledge of those terms. Any benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and third, respectively.

If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. Continuation coverage. Continuation coverage provided under either federal or state law is secondary. If the other plan does not have this rule, this rule is ignored.
4. Length of coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary.

If this Plan is determined to be secondary, benefits payable under this Policy will be reduced so that the total benefits provided by all plans during a claim determination period are not more than the total Allowable Expenses for the Insured Individual. The Company will use the amount by which benefits have been reduced to pay Allowable Expenses, not otherwise paid, which were incurred during the claim determination period and have been submitted for that person.

The actual benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Policy will never exceed the amount that would have been paid if there were no other plans involved. If benefit payments under this Policy are reduced by COB, only the reduced amounts will be charged against the Insured Individual's plan maximums.

If during Coordination of Benefits, payments are made in error, the plans will have the right to adjust payments among themselves. Such payments satisfy the Company's liability. If a claim is overpaid under this Policy, the Company has the right to recover such overpayments from any person for, to whom, or with respect to whom such payments were made, any other insurance company, or any other organization.

Definitions

An "**Allowable Expense**" is the Reasonable and Customary cost for any necessary medical, dental or health care service which is covered (at least in part) by one of the plans. If a health plan provides services (rather than cash payments) a dollar value will be assigned in order to use this provision.

When the primary plan penalizes an Insured Individual for not complying with plan provisions, such as failing to pre-certify, the amount of the reduction is not considered an Allowable Expense.

[A "**Benefit Determination Period**" means from [January 1] of one year to [December 31] of the [same] [next] year.]

A "**plan**" as used in this provision, is any of the following that provide health benefits or services:

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;
3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. government plans, except Medicaid;
6. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
7. no-fault auto insurance on an individual basis, except where not allowed by the state in which this Plan is issued;
8. single or family subscribed plans issued under a group or blanket type plan;

but the definition of plan shall not include:

1. hospital indemnity type plans;
2. school accident-type coverage.]

DENTAL CARE BENEFITS

IMPORTANT NOTICE: The DENTAL CARE BENEFITS only apply to Policy BLK-4554-[XXX] [(Reissued)], if it is so specified in the POLICY SCHEDULE or otherwise added by Amendment.

Each Insured Individual covered under the [Outbound] [Domestic] [International] Policy has a Dental Care Benefits calendar year maximum of [\$1,500].

| Services | The Plan Will Pay | Deductible Applies |
|---------------------------------|------------------------------|-------------------------------|
| [Preventive and Diagnostic Care | [80%] | [Yes/No]] |
| [Basic Dental Care | [50%] | [Yes/No]] |
| [Oral Surgery | [50%] | [Yes/No]] |

When an Insured Individual incurs Covered Dental Care Expenses exceeding the Deductible, benefits will be payable for those expenses up to the calendar year maximum and benefit percentages shown above.

DEDUCTIBLE

The **Deductible**, means the dollar amount of a Covered Dental Care Expense which must be incurred as an out-of-pocket expense by each Insured Individual before benefits are payable under the Policy and will be applied as follows:

With respect to any Insured Individual, the Deductible equals Covered Dental Care Expenses in the amount of [\$25] per Calendar Year.

INSURING CLAUSE

Subject to the exclusions, limitations, and all other provisions of the Policy, Dental Care Benefits are payable for a Covered Dental Care Expense if:

1. the Deductible requirement, if any, is met;
2. the expense is incurred while insured for this coverage;
3. the Insured Individual has not exceeded the Policy's Dental Care Benefits maximum.

COVERED DENTAL CARE EXPENSE

Covered Dental Care Expense means only the expense actually incurred for dental care, treatment, services, and supplies by an Insured Individual which are Medically Necessary and meet the following conditions:

1. are performed by a Dentist or a licensed dental hygienist acting under the supervision and direction of a Dentist;
2. are not excluded by any provisions contained in the Policy; and
3. are not more than the Reasonable and Customary charges (as defined by the Policy).

To determine if dental care and supplies and the expense charged are Reasonable and Customary, the Company will consider the dental care or supplies usually given and the fees usually charged for like dental care in that Area.

The Company will consider each Covered Dental Care Expense to be incurred on the date the dental care or supply is received. Covered Dental Care Expenses under the Policy are limited to the following:

- [1. Preventive and Diagnostic Care which means:
 - a. initial oral examination;
 - b. clinical oral exams, but not more than [one] in [six] consecutive months;
 - c. emergency oral exam;
 - d. x-ray exams:
 - i. panorex film, but not more than [one] in [36] consecutive months;
 - ii. full mouth x-ray, but not more than [one] in [36] consecutive months;
 - iii. individual periapical x-rays; and
 - iv. bitewing x-rays; but not more than [one] in [six] consecutive months;
 - e. dental prophylaxis, but not more than [one] in [six] consecutive months;
 - f. topical application of fluoride for an eligible Child, but not more than [one] in [six] consecutive months.]
- [[2.] Basic Dental Care which means care and supplies for fillings (amalgams).

The Policy will **not** pay benefits for Basic Dental Care expenses incurred within the first 6 months after an Insured Individual becomes covered for this benefit.]

- [[3.] Oral Surgery which means care and supplies for:
 - a. extractions of erupted and unerupted (impacted) teeth;
 - b. crowns;
 - c. root canals therapy (endodontic care).

The Policy will **not** pay benefits for Oral Surgery expenses incurred within the first [12] months after an Insured Individual becomes covered for this benefit.]

DENTAL CARE EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for Dental care or supplies which are not included under Covered Dental Care Expense;
- [2.] for Dental care or supplies furnished outside the United States;]
- [3.] in excess of Reasonable and Customary charge;
- [4.] for Injury resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
- [5.] for dental care, treatment, services, and supplies for which no charge is made or no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
- [6.] for Injury if covered to any extent under: any occupational benefit plan; Worker's Compensation or similar law; dental payments under individual automobile insurance (except for no-fault auto insurance);
- [7.] for dental care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy;
- [8.] for intentionally self-inflicted Injury or Injury resulting from taking part in the commission of an assault or felony;
- [9.] for Dental care or supplies payable under another part of the Policy;
- [10.] for charges incurred after the Insured Individual is no longer covered for this Dental Care Benefit;
- [11.] for overdentures and associated procedures;
- [12.] for cosmetic procedures;
- [13.] for denture duplication;
- [14.] for the replacement of bridges, full or partial dentures, crowns, inlays or onlays that can be repaired and restored to natural function;
- [15.] for implants;
- [16.] for the replacement of (a) lost or stolen appliances, or (b) orthodontic retainers;
- [17.] for athletic mouthguards;
- [18.] for precision or semi-precision attachments;
- [19.] for sealants;
- [20.] for plaque control;
- [21.] for acid etch;
- [22.] prescription or take-home fluoride;
- [23.] for oral hygiene instructions; and for (a) the completion of a claim form; (b) broken appointments; or (c) diagnostic photographs; and
- [24.] for procedures that are begun, but not completed.

DEFINITIONS - Dental Care Benefits

Unless separately defined herein, wherever used in the Dental Care Benefits section of the Policy:

1. **Close Relative** means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.
2. **Dentist** means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.
3. **Injury** means an accidental dental injury sustained by an Insured Individual which results directly from an accident which occurs independent of any and all other causes.
4. **Insured Individual:** means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements.
5. **Insured Student** means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
6. **Medically Necessary** means only care and treatment the Company determines meets all of the following conditions:
 - a. the care and treatment is Appropriate given the symptoms and is consistent with the diagnosis, if any. **"Appropriate"** means that the type, level and length of service and setting are needed to provide safe and adequate care and treatment;
 - b. it is rendered in accordance with generally accepted medical practice and professionally recognized standards;
 - c. it is not treatment that is generally regarded as experimental or unproven; and
 - d. it is specifically allowed by the licensing statutes which apply to the provider who renders the service.
7. **Policy** means the Policy including all amendments, riders and endorsements.
8. **Policyholder** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.
9. **Sickness** means a dental infirmity of an Insured Individual that is the sole cause of loss.
10. **Reasonable and Customary** means, with regard to charges for dental services or supplies, the lowest of:
 - a. the usual charge by the provider for the same or similar dental services or supplies;
 - b. the usual charges of most providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies; or
 - c. the actual charge for the services or supplies.

"Area" means the location where the dental care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of dental care or supplies.

OPTIONAL STUDENT ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

IMPORTANT NOTICE: The ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) benefits only apply to Policy BLK-4554-[XXX] [(Reissued)], if it is so specified in the POLICY SCHEDULE or otherwise added by Amendment.

SCHEDULE

Student Only Coverage

| | |
|------------------------------|--|
| [Maximum Amount of Insurance | [\$5,000]] |
| [Maximum Amount of Insurance | An amount in increments of \$5,000 equal to the amount selected by the Policyholder/Educational Facility for all of its Insured Students, not to exceed \$50,000.] |

[Reduction Schedule]

[The benefit amount at age 65 or over will be reduced to [50%] of the otherwise applicable amount.]

[Coverage terminates at age 70.]

* * * * *

Benefit: means the amount the Company will pay for covered losses.

The Company will pay the applicable amount of AD&D Benefit if the Insured Student suffers the loss of life, limb or sight as the direct result of an Injury while covered for this Benefit. But the Company will only pay the Benefit after the Company receives written proof of such loss at its home office. The loss must be incurred within [90 days] of the accident.

[The Company will pay the following for the [accidental loss of] [total use of] :

| | |
|---|----------------------------------|
| [Life | The maximum amount] |
| [A hand by severance through or above the wrist | One-half the maximum amount] |
| [A foot by severance through or above the ankle | One-half the maximum amount] |
| [Irrecoverable loss of sight of one eye | One-half the maximum amount] |
| [Speech or hearing | One-half the maximum amount] |
| [Quadriplegia*] | [The maximum amount] |
| [Paraplegia or Hemiplegia*] | [One-half the maximum amount] |
| [Thumb and index finger of same hand] | [One-quarter the maximum amount] |

[* **“Quadriplegia”** means total Paralysis of both upper and lower limbs; **“Paraplegia”** means both lower limbs; **“Hemiplegia”** means total Paralysis of upper and lower limbs on one side of the body. **“Paralysis”** means loss of use, without severance, of a limb. This loss must be determined by a Doctor to be complete and not reversible.]

| | |
|--|-------------------------------|
| [Both hands or both feet | The maximum amount] |
| [Sight of both eyes | The maximum amount] |
| [Combination of two: hand, foot or sight | The maximum amount] |
| [Speech and hearing | The maximum amount] |
| [One hand, one foot or sight of one eye | One-half the maximum amount] |
| [Two or more Members**] | [The maximum amount] |
| [Irrecoverable loss of speech and hearing (both ears)] | [The maximum amount] |
| [One Member**] | [One-half the maximum amount] |
| [Irrecoverable loss of speech or hearing (both ears)] | [One-half the maximum amount] |

[** “**Member**” means hand, foot or eye.]

[The Company will not pay more than the maximum Benefit amount for all losses the Insured Student suffers as a result of one accident. Payment will be made to the Insured Student. Benefits for accidental loss of life will be paid as shown under the Beneficiary provision.]

[ONE amount, the largest, will be paid for all Injuries resulting from one accident.]

EXCEPTIONS AND EXCLUSIONS

The Company will not pay any AD&D Benefit for loss connected in any way with:

- [1.] [Bodily or mental conditions that existed at the time of or prior to the accident.]
- [2.] [Intentionally self-inflicted Injury; suicide, or attempted suicide, while sane or insane; or Injury resulting from taking part in the commission of an assault or felony.]
- [3.] [Ptomaine or bacterial infection other than a pyogenic infection that results from an accidental bodily Injury, or a bacterial infection that results from the accidental ingestion of contaminated substances.]
- [4.] [Act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder.]
- [5.] [Aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly schedule commercial airline.]
- [6.] [Accidental bodily Injury if it arises out of employment for pay, profit or gain.]
- [7.] [Operating any vehicle, if at that time the Insured Student had a blood alcohol level greater than the legal limit as determined by the laws and/or decision of the jurisdiction in which the loss occurred.]
- [8.] [Loss suffered in the Student’s home country or country of regular domicile.]
- [9.] [Loss suffered while the Insured Student is ineligible for this coverage.]

BENEFICIARY

“**Beneficiary**” means the person(s) who will receive the Insured Student’s accidental loss of life benefit. Unless the Insured Student indicates otherwise, the Company will pay the Benefit in this order to:

1. the Insured Student’s spouse, if living;
2. the Insured Student’s Children, in equal shares;
3. the Insured Student’s parents, in equal shares, or to the survivor;
4. the Insured Student’s estate (if no Beneficiary survives the Insured Student).

The Insured Student can name or change the Beneficiary at any time by sending written notice to the Company’s home office on a form the Company approves. If the Insured Student names more than one Beneficiary, the Company will pay the Benefit in equal shares unless the Insured Student indicates otherwise.

If the Company pays the Benefit before receiving the notice of a change in Beneficiary, the Company does not have to pay the Benefit again. If the Insured Student’s Beneficiary dies before the Insured Student does, the Company will pay the Benefit to any remaining Beneficiaries.

[When this plan replaces a Group Policy the Company previously issued (and under which the Insured Student was previously covered) the Insured Student’s named Beneficiary and his/her elected settlement option will remain the same unless changed by the Insured Student as shown above.]

DEFINITIONS - Accidental Death and Dismemberment

Unless separately defined herein, wherever used in Accidental Death and Dismemberment section of the Policy:

1. **Injury** means an accidental bodily injury sustained by an Insured Student which results directly from an accident which occurs independent of any and all other causes.
2. **Insured Student** means an individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
3. **Physician or Doctor** means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.
4. **Policy** means the Policy including all amendments, riders and endorsements.
5. **Policyholder** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.

CLAIM PROVISIONS

Notice and Proof of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Company (or its authorized representative) within 60 days after the event, or as soon thereafter as is reasonably possible. When the Company receives the notice of claim, it will send the claimant forms for filing proof of claim. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of claim requirements by giving the Company a statement in writing of the nature and extent of the loss within the time required.

Written proof of loss must be furnished to the Company within 90 days after the date of loss. However, in case of claims for loss for which the Policy provides any payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the company is liable. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss. If it was not reasonably possible to give notice and proof in writing in the time required, the Company shall not reduce or deny the claim for this reason if proof is filed as soon as reasonably possible.

Payment of Claim: Benefits will be paid as soon as the Company receives satisfactory proof of loss. All benefits [(other than for accidental loss of life)] will be paid to the Insured Student subject to any written assignment of benefits by the Student which is authorized by the Policy and made on a form satisfactory to the Company.

[If an Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.]

If the Insured Student dies without making a written assignment of benefits, the Company will pay benefits to the Insured Student's estate. The Company may, at its option, pay all or part of the benefits to a provider or person who treats or cares for the Insured Individual. Such payment made in good faith will discharge the Company to the extent of the amount paid.

Physical Examinations and Autopsy: The Company, at its own expense, has the right to examine the person with respect to whom benefits are claimed as often as reasonably needed while the claim is pending. It may also have an autopsy made unless against the law.

Legal Actions: No action at law or in equity may be brought to recover on the Policy before the end of 60 days and after proof in writing of the loss has been given, as required by the Policy. No such action may be brought after 3 years from the time written proof of loss is required to be given or after such shorter period of years allowed by law in the applicable jurisdiction.

Assignments and Claims of Creditors: The Insured Student may assign the Major Medical Benefits (and Dental Care Benefits, if any) under the Policy only to such person or institution rendering services or furnishing supplies for which benefits are payable. The Company shall not be responsible for the validity of any such assignment. Any payment made according to such assignment and in good faith by the Company will discharge the Company to the extent of any such payment.

[If an Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.]

To the extent permitted by law, neither the benefits nor payments under the Policy will be subject to the claim of creditors or to any legal process by any creditor of the Insured Individual or beneficiary.

Right of Reimbursement: The Company shall have a lien against any recovery received by an Insured Individual as compensation for an Injury or Bodily Infirmary to the extent that the Insured Individual received benefits for such Injury or Bodily Infirmary under the coverage of the Policy. The Company's lien will apply to such recovery made by the Insured Individual from any person, or entity that was responsible for causing such Injury or Bodily Infirmary or their insurers. The Insured Individual will not be required to return to the Company more than the amount which was recovered for such Injury or Bodily Infirmary.

The Insured Individual (or a parent or a guardian if the Insured Individual is not able to execute such papers) will execute and deliver such papers as may be required by the Company. Also, the Insured Individual will do whatever else is needed to help the Company in its attempts to recover the benefits it paid under the Policy to the Insured Individual or the individual's assignee.

GENERAL POLICY PROVISIONS

Entire Contract: [The entire contract is made up of this Policy, with the attached copy of the Policyholder's application and other attached papers, if any; and the attached individual applications, if any.] [The entire contract is made up of this Policy, with the attached copy of the Policyholder's application for Policy [BLK-4554-XXX], the amendment in acceptance of enhanced benefits under Policy [BLK-4554-XXX (Reissued)] and other attached papers, if any; and the attached individual applications, if any.]

All statements made by the Policyholder or by an Insured Individual shall be deemed representations and not warranties. Misstatements shall not be used in any context or to reduce claims under this Policy, unless it is in writing. A copy of the application containing such misstatement must have been given to the Policyholder, the Insured Individual or to his beneficiary, if any.

Misstatement of Age: If the age of an Insured Individual has been misstated, any amounts payable will be the ones the premium would have purchased at the correct age. Any such misstatement shall neither continue insurance ended by valid means nor void insurance otherwise valid and in force.

Sex and Number: When used in the Policy, the masculine includes the feminine; the singular, the plural; and the plural, the singular.

Clerical Error: Clerical error by the Policyholder or the Company shall not make the coverage of an ineligible person valid nor continue coverage that was ended by valid means. Neither the passage of time nor the payment of premiums for a person who is not eligible for coverage under the terms of this Policy will make this coverage valid for such person. If it is found that such a person was included when the premium was figured for this Policy, the only liability of the Company shall be the proper refund of premiums. In addition, when a person is no longer eligible for coverage under this Policy, the payment of premiums for such person shall not continue coverage past the date such person ceases to be eligible. Again, the only liability of the Company shall be the proper refund of premiums.

Authority: No agent has the right to change the Policy or to waive any part of it. Waiver of any provision of the Policy by the Company shall not effect its right to enforce the provision at any time thereafter against any person or entity claiming rights under the Policy.

Policy Changes: The Policy may be amended at any time by the Company without the consent of any person or entity claiming rights under the Policy and without notice to any Insured Individual or any person or entity claiming rights through them or on their behalf. However, the Company will provide at least 30 days advance written notice to the Policyholder of any amendments to the Policy.

Termination of This Policy: The Policyholder may cancel this Policy by giving notice, in writing, to the Company at its home office. This Policy will be in effect until the later of:

1. the date the Company receives such notice; or
2. the date set by such notice;

subject to the Policy ending prior to this notice because of the Grace Period.

If premiums are not paid, this Policy shall end as stated in the Grace Period.

[The Company may refuse to renew or continue in force the health care coverage under this Policy by giving notice, in writing to the Policyholder, at least 31 days prior to the date it is to be canceled:

1. for fraud or intentional misrepresentation of material fact by the Policyholder; [or]
2. if the Company's minimum participation requirements cannot be met[;].[.] [or]
- [3. with respect to a Provider network, if there is no longer any Insured Individual who lives or attends school in the service area].]

[The Company may end Accidental Death and Dismemberment coverage, if any, by giving notice in writing to the Policyholder at least 31 days prior to the date it is to be canceled.]

The Company may terminate this policy by giving notice, in writing, to the Policyholder at least 31 days prior to the date insurance will end if the following minimum participation requirements are not met:

1. the number of Insured Students is less than [10] during any school term other than the summer term; or
2. if less than 100% of those Eligible Students who do not already have medical or health care coverage from other sources are insured under this Policy.

[If the Company discontinues a particular type of health coverage, the Company will provide notice to the Policyholder at least 90 days prior to the discontinuance of such type of coverage. The Policyholder will be given the option to purchase other health coverage currently being offered in the same market. The Policyholder will be responsible for distribution of the notices to those covered under the Policy. The Company will comply with any required state notices.

If the Company elects to discontinue all group health coverage in a market, the Company will provide notice to the Policyholder and to the [state] Insurance Department at least 180 days prior to the nonrenewal or the discontinuance of such health coverage. The Policyholder will be responsible for distribution of the notice to those covered under the Policy.

The Company may end the health care coverage only for reasons stated in the Policy or with the express consent of the [state] Insurance Department.]

Cancellation of the Policy or any of its provisions may be without the consent of the Policyholder or any person claiming rights or benefits under this Policy. If this Policy cancels, it shall not affect any claim that begins before the date this Policy or such provision ends, subject to the terms and conditions of this Policy.

The Company shall refund the pro rata portion of any premium paid for a period of time beyond the date on which the Policy ends.

SERFF Tracking Number: CCGH-125860743 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 40649
Company Tracking Number:
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student Blanket
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CCGH-125860743 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 40649
Company Tracking Number:
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student Blanket
Project Name/Number: /

Supporting Document Schedules

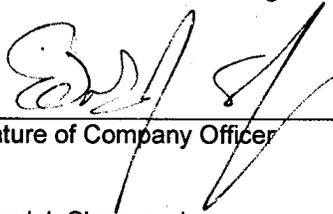
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| Satisfied -Name: Certification/Notice | Review Status: Approved-Closed | 10/29/2008 |
| Comments: | | |
| Attachments: Arkansas Certificate of Compliance.pdf ReadCert.pdf | | |
| Satisfied -Name: Application | Review Status: Approved-Closed | 10/29/2008 |
| Comments: | | |
| Attachment: SBAppAR.pdf | | |
| Satisfied -Name: List of Forms | Review Status: Approved-Closed | 10/29/2008 |
| Comments: | | |
| Attachment: ListofFormSBAR.pdf | | |
| Satisfied -Name: Variable Memo | Review Status: Approved-Closed | 10/29/2008 |
| Comments: | | |
| Attachment: SB Variable Memo.pdf | | |
| Satisfied -Name: Offer Form | Review Status: Approved-Closed | 10/29/2008 |
| Comments: | | |
| Attachment: OfferForm_04-06_.pdf | | |

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Connecticut General Life Insurance Company

Form Number(s): BLK97(AR)(04-06), BLK97-PS(AR)(04-06), BLK97-E(AR)(04-06),
BLK97-P(AR)(04-06), BLK97-MMB(AR)(04-06),
BLK97-MMPPPO(AR)(04-06), BLK97-CE(AR)(04-06),
BLK97-EX(AR)(04-06), BLK97-D(AR)(04-06), BLK97-COB(AR)(04-06),
BLK97-DC(AR)(04-06), BLK97-ADD(AR)(04-06), BLK97-CP(AR)(04-06),
BLK97-GPP(AR)(04-06), AppOffer(AR)(04-06), LWRBI(G)(04-06)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Edmund J. Skowronek

Name

Compliance Director

Title

October 21, 2008

Date

**ARKANSAS
CERTIFICATION OF READABILITY**

Connecticut General Life Insurance Company

FORM NUMBERS:

BLK97(AR)(04-06), BLK97-PS(AR)(04-06), BLK97-E(AR)(04-06),
BLK97-P(AR)(04-06), BLK97-MMB(AR)(04-06),
BLK97-MMPP(AR)(04-06), BLK97-CE(AR)(04-06),
BLK97-EX(AR)(04-06), BLK97-D(AR)(04-06), BLK97-COB(AR)(04-06),
BLK97-DC(AR)(04-06), BLK97-ADD(AR)(04-06), BLK97-CP(AR)(04-06),
BLK97-GPP(AR)(04-06), AppOffer(AR)(04-06), LWRBI(G)(04-06)

This is to certify that the forms listed above have achieved a Flesch Reading Ease Score of “40 plus” and complies with the requirements of Arkansas Statutes Annotated 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Edmund J. Skowronek
Compliance Director

October 21, 2008

Date

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

900 Cottage Grove Road
Hartford, Connecticut 06152

APPLICATION FOR BLANKET INSURANCE

The undersigned Applicant hereby applies to the Connecticut General Life Insurance Company (the Company) for a Blanket Accident and Sickness Policy providing the insurance plan checked below, to be effective: _____

Classification

- International Students Outbound Students Domestic Students

Options

- Deductible Plan Doctor/Hospital Copayment Plan Accidental Death and Dismemberment
 Dental Care Benefits Other _____

IT IS UNDERSTOOD AND AGREED THAT:

- (1) The conditions of eligibility for blanket insurance, the insurance coverage, benefits and amounts, the conditions under which the benefits will be payable, and other terms and conditions shall be in accordance with the Policy issued and any amendments, riders or endorsements thereto, which together with the copy of the Application attached to the Policy and the individual applications, if any, of the persons to be insured shall constitute the entire contract.
- (2) No person other than a duly authorized officer of the Company at its home office has authority to accept this application or otherwise bind the Company.
- (3) The blanket insurance shall become effective provided:
 - (a) this Application is accepted by a duly authorized officer of the Company at its home office;
 - (b) 100% of eligible individuals who do not already have medical or health care coverage from other sources are insured.
- (4) The Applicant, as Policyholder, shall furnish the Company, or its authorized agent, with eligibility and coverage information concerning individuals to be insured or whose blanket insurance is to be changed or discontinued.
- (5) The blanket insurance applied for is not in addition to any other insurance on a group, blanket, or similar basis except (if no exceptions, so state): _____
- (6) The blanket insurance applied for does not replace any other insurance on a group, blanket, or similar basis except (if no exceptions, state none): _____
- (7) This Application may be amended solely on the basis of a written request of the undersigned Applicant made at any time prior to its acceptance by the Company, and the Company is hereby authorized to modify this Application in accordance with any such written request; provided further that any amendment of the Policy which affects the terms of this Application shall also be considered an amendment of the Application.
- (8) _____ is hereby designated as Agent or Broker entitled to receive any compensation payable on the Policy issued pursuant to this Application.

Any person who knowingly and with intent to defraud or deceive an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud. Such fraudulent application can cause the Company to rescind the Policy.

| | | | |
|--|------|---|------|
| Printed Name and Title of Licensed Agent or Broker | | Educational Organization | |
| Signature of Licensed Agent or Broker | | Printed Name and Title of Applicant signing on behalf of Educational Organization | |
| | | Signature of Applicant | |
| Dated at (City/State) | Date | Dated at (City/State) | Date |

**STUDENT BLANKET
LIST OF FORMS - ARKANSAS**

| <i>Form Description</i> | <i>State Approval Date</i> | <i>State/SERFF Filing Identifier</i> | <i>Form Number</i> |
|--|----------------------------|--------------------------------------|-----------------------|
| APPLICATION | | | |
| Application | 5/5/2006 | Not Available | LWRBI(G)(04-06) |
| OFFER FORMS | | | |
| Offer Forms (Musculoskeletal Disorders, Hospice Care, Professional Counselors) | 5/5/2006 | Not Available | AppOffer(AR)(04-06) |
| POLICY | | | |
| POLICY SIGNATURE PAGE | 5/5/2006 | Not Available | BLK97(AR)(04-06) |
| POLICY SCHEDULE | 5/5/2006 | Not Available | BLK97-PS(AR)(04-06) |
| TABLE OF CONTENTS | 5/5/2006 | Not Available | Table |
| ELIGIBILITY (AND EFFECTIVE/TERMINATION DATES) | 5/5/2006 | Not Available | BLK97-E(AR)(04-06) |
| PREMIUM | 5/5/2006 | Not Available | BLK97-P(AR)(04-06) |
| MAJOR MEDICAL BENEFITS (DEDUCTIBLE) | 5/5/2006 | Not Available | BLK97-MMB(AR)(04-06) |
| MAJOR MEDICAL BENEFITS (COPAYMENT) | 5/5/2006 | Not Available | BLK97-MMPP(AR)(04-06) |
| COVERED EXPENSES | 5/5/2006 | Not Available | BLK97-CE(AR)(04-06) |
| EXCEPTIONS AND EXCLUSIONS | 5/5/2006 | Not Available | BLK97-EX(AR)(04-06) |
| DEFINITIONS | 5/5/2006 | Not Available | BLK97-D(AR)(04-06) |
| COORDINATION OF BENEFITS | 5/5/2006 | Not Available | BLK97-COB(AR)(04-06) |
| DENTAL CARE BENEFITS | 5/5/2006 | Not Available | BLK97-DC(AR)(04-06) |
| OPTIONAL AD&D | 5/5/2006 | Not Available | BLK97-ADD(AR)(04-06) |
| CLAIMS PROVISIONS | 5/5/2006 | Not Available | BLK97-CP(AR)(04-06) |
| GENERAL POLICY PROVISIONS | 5/5/2006 | Not Available | BLK97-GPP(AR)(04-06) |

GENERAL POLICY VARIABLES

1. Forms may be included or omitted according to the benefits selected by the policyholder.
2. Forms may appear in a different order than as submitted for approval.
3. All bracketed numbers and dollar amounts are variable. Any limits are indicated by either the symbol \leq or \geq . Otherwise, limits are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.
4. Bracketed items, sentences and paragraphs are variable and may be included or omitted according to the particular policyholder's specific plan of insurance.
5. Specific items may appear on different pages within the form depending upon how the provisions applicable to the policyholder fit on a page.
6. Capitalization may vary depending upon the omission of a beginning bracketed phrase or by policyholder request.
7. If one or more of a series of items are omitted, numbering or lettering will be adjusted appropriately.
8. Commas will be omitted when the optional item is omitted.
9. Colons, semicolons, semicolons followed by either the words, "or", "and" or "and/or" may be omitted. If omitted, a period will be substituted, if necessary.
10. The words "Insured Student" and "Policyholder" are completely variable to incorporate the exact eligible groups for a specific policyholder.
11. Numbers may be spelled out or numeric.
12. All references to coverage of dependents may be omitted unless dependent coverage exists.
13. Definitions may vary to the extent that the definition may be included, omitted or appear in a different location on the form to suit the needs of a particular policyholder.
14. The "home office" is usually the designated place where all administrative functions are performed. However, another "appropriate office" may be designated to perform a specific function.

SPECIFIC POLICY VARIABLES

BLK97(AR)(04-06) - Bracketed items will vary according to the policyholder's plan of benefits. Additional titles may be added to that of President.

BLK97-PS(AR)(04-06) - Bracketed items will vary according to the policyholder's plan of benefits.

BLK97-E(AR)(04-06) - Eligibility, Effective and Termination Dates of Individual Coverage.

Bracketed items with regard to [international][and practical training] [outbound], [domestic], [visiting faculty], [scholar], [or] [other persons of similar description] will vary according to the policyholder's plan of benefits.

Bracketed items [two-semester][trimester][quarter] will vary according to the policyholder request.

Newborn Infants - Well Baby Care - may be included or omitted upon policyholder request.

Extended Coverage – Generally included if the policyholder elects coverage of international students. May also be included at policyholder request if the policyholder covers domestic outbound students.

BLK97-P(AR)(04-06) - The information concerning the required premium rates for each type of coverage may be included or omitted depending on whether the policyholder's plan provides such coverage.

Premium due dates - standard is first day of the school term. Text is available to be payable each month.

Grace Period – 30 days is standard grace period, but is subject to change based on Connecticut General Life Insurance Company's policies and procedures.

BLK97-MMB(AR)(04-06) - This form is used if the policyholder purchases the Deductible plan.

The bracketed dollar amounts are variable and are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.

The Student per Accident and Sickness benefit maximum is generally higher than the Dependent per Accident and Sickness amount, and the dollar amounts vary depending on policyholder request. Upon request, the Student and Dependent maximum dollar amounts may be the same amount.

The 12-month 'all Accidents and Sickness' benefit maximum dollar amount varies depending on policyholder request.

Deductible – The dollar amounts vary depending on policyholder request.

BLK97-MMPP(AR)(04-06) - This form is used if the policyholder purchases a PPO plan.

The bracketed dollar amounts are variable and are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.

The Student per Accident and Sickness benefit maximum is generally higher than the Dependent per Accident and Sickness amount, and the dollar amounts vary depending on policyholder request. Upon request, the Student and Dependent maximum dollar amounts may be the same amount.

The 12-month 'all Accidents and Sickness' benefit maximum dollar amount varies depending on policyholder request.

Copayment Benefit Schedule – The copay amounts vary depending on policyholder request.

Generally, the copay amounts for participating provider services are lower than the copay amounts for non-participating provider services.

Generally, the copay amounts for Emergency Room treatment of a Sickness is higher than the copay amount for Emergency Room treatment of an Accident. These may be the same dollar amount if requested by a policyholder.

The "Out-of-Pocket Expense Maximum" provision may be omitted upon policyholder request.

BLK97-CE(AR)(04-06) - Covered Expense

The bracketed numeric values and dollar amounts are variable and are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.

Bracketed provisions and phrases may be included or omitted, depending on policyholder request and the type of plan (Deductible or PPO) purchased.

BLK97-EX(AR)(04-06) - Exceptions and Exclusions

The bracketed numeric values and dollar amounts are variable and are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.

Bracketed provisions and phrases may be included or omitted, depending on policyholder request and the type of plan (Deductible or PPO) purchased.

BLK97-D(AR)(04-06) - Bracketed provisions and phrases may be included or omitted, depending on policyholder request and the type of plan (Deductible or PPO) purchased.

BLK97-COB(AR)(04-06) – Generally, COB is included in policies, but may be omitted upon Policyholder request or a change in Connecticut General Life Insurance Company's policy and practices.

BLK97-DC(AR)(04-06) – Dental Care Benefits are included if elected by the Policyholder. The bracketed numeric values and dollar amounts are variable and are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.

BLK97-ADD(AR)(04-06) – Accidental Death & Dismemberment benefits are included if elected by the Policyholder. The bracketed numeric values and dollar amounts are variable and are governed by Connecticut General Life Insurance Company's policy and practices, policyholder request and state or federal law.

BLK97-CP(AR)(04-06) – Claim Provisions. Bracketed provisions and phrases may be included or omitted, depending on Connecticut General Life Insurance Company's policy and practices, policyholder request and the type of plan purchased.

BLK97-GPP(AR)(04-06) – General Policy Provisions. Bracketed provisions and phrases may be included or omitted, Depending on Connecticut General Life Insurance Company's policy and practices, policyholder request and the type of plan purchased.

ARKANSAS
MUSCULOSKELETAL DISORDERS
OFFER FORM

The state of Arkansas requires that all group insurance companies offer the following optional benefit for musculoskeletal disorders to policyholders. **Additional premium may be required if this benefit is elected.**

This benefit provides coverage for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder. Benefits will be payable on the same basis as any other musculoskeletal disorder.

Statement of Intent

I have been given the opportunity to apply for the Arkansas benefit for musculoskeletal disorders and elect as follows:

_____ I **reject** the optional coverage

_____ I **accept** the optional coverage

Signed _____

Title _____

Name of Policyholder _____

Date _____

ARKANSAS
COVERAGE FOR HOSPICE CARE
OFFER FORM

Arkansas State Insurance Law requires that policyholders be offered the option to purchase Hospice Care coverage. A brief description of the benefits is below. **Additional premium may be required if this benefit is elected.**

Hospice Care Benefits

- a. the Insured Individual's must Physician recommend in writing on or before hospice care is started
- b. the Insured Individual must elect (in writing to Us) to follow the Physician's proposed treatment plan;
- c. such care must be administered by a licensed Hospice Care Facility;
- d. coverage is limited to a maximum of 6 months, with an additional 6 months of care in cases where the patient is facing imminent death or is entering remission, if certified in writing by the attending Physician.

Coverage under this provision ends if the Insured Individual elects (in writing to Us) to discontinue Hospice care.

Hospice Care Benefits are not payable for:

- a. services provided by persons who do not regularly charge for their services;
- b. counseling which is not provided as part of the Hospice care plan;
- c. services provided by homemakers, caretakers and the like;
- d. funeral expense;
- e. treatment intended to cure the terminal illness.

Statement of Intent

I have been given the opportunity to apply for special coverage for Hospice Care as required by Arkansas Insurance Law. As is my option as an applicant for group insurance,

_____ I **reject** application for such coverage

_____ I **accept** application for such coverage

Signed _____

Title _____

Name of Group _____

Date _____

ARKANSAS
LICENSED PROFESSIONAL COUNSELORS
OFFER FORM

The State of Arkansas requires that all group and blanket medical plans issued in that state offer coverage for payment of services rendered by licensed professional counselors acting within the scope of their practice and possessing the necessary qualifications as defined by the Arkansas Board of Examiners for counseling.

If elected, the amount payable for these services shall be subject to the same limitations, if any, set forth in the plan for mental health coverage.

NOTE: Election of the optional coverage described above may require payment of additional premiums.

Statement of Intent

I have been given the opportunity to apply for the special Arkansas benefit for coverage of services rendered by licensed professional counselors, and elect as follows:

_____ I **reject** the optional coverage

_____ I **accept** the optional coverage

Signed _____

Title _____

Name of Group _____

Date _____

SERFF Tracking Number: *CCGH-125860743* *State:* *Arkansas*
Filing Company: *Connecticut General Life Insurance Company* *State Tracking Number:* *40649*
Company Tracking Number:
TOI: *H04 Health - Blanket Accident/Sickness* *Sub-TOI:* *H04.001 Student*
Product Name: *Student Blanket*
Project Name/Number: /

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Original Date: | Schedule | Document Name | Replaced Date | Attach Document |
|-----------------------|-----------------|------------------------------------|----------------------|------------------------|
| No original date | Form | Blanket Accident & Sickness Policy | 10/22/2008 | PolicyAR.pdf |

CONNECTICUT GENERAL

LIFE INSURANCE COMPANY
900 Cottage Grove Road
Hartford, Connecticut 06152
(herein called "the Company")

[Deductible] [Copayment][Plus] Plan

[INTERNATIONAL] [OUTBOUND] [DOMESTIC] BLANKET ACCIDENT AND SICKNESS POLICY

the Company issues to

Any Educational Organization]
(herein, the "Policyholder")

Policy Number: BLK-4554-[XXX] [(Reissued)]
(herein, the "Policy")

Policy Year: [November 1 through the following October 31]

Effective Date: [November 1, 2002]

Place of Delivery: State of []

This Policy is governed by the laws of the State of [] and other applicable laws and regulations.

In consideration of the Policyholder's application and timely payment of premium, the Company will pay applicable benefits to eligible insureds. Such payment is subject to all provisions of this Policy.

This Policy is non-participating.

Signed at the office of CONNECTICUT GENERAL LIFE INSURANCE COMPANY on this [1st] day of [February] [2003].

[Secretary]

President

POLICY SCHEDULE

A. The [International] [Outbound] [Domestic] Blanket Accident and Sickness Policy number BLK-4554-[XXX] [(Reissued)], as issued to the Policyholder, contains a number of optional insurance benefits. However, only the insurance benefit(s) selected by the Policyholder, as described in B. below, will apply to and be in effect for the Policyholder and any person insured under such Policyholder's insurance Policy.

B. Based on the Policyholder's selection, made at the time of the application, only those insurance benefit(s) identified below with a "Yes" notation, accompanied by a signature of the Company's authorized personnel, is/are applicable to the Policyholder.

| | | | |
|-------|------------------------------------|----------|------------|
| _____ | Major Medical Benefits: | [Yes/No] | Signature: |
| | ___ Student Only | | |
| | ___ Student and Spouse | | |
| | ___ Student, Spouse and Child(ren) | | _____ |

| | | | |
|---------|--|----------|--------------------|
| [_____] | Optional Accidental Death and Dismemberment (AD&D) (Student Only Coverage) | [Yes/No] | Signature: _____] |
|---------|--|----------|--------------------|

| | | | |
|---------|---------------------------------|----------|------------|
| [_____] | Dental Care Benefits | [Yes/No] | Signature: |
| | ___ Student Only | | |
| | ___ Student and Spouse | | |
| | ___ Student, Spouse, Child(ren) | | _____] |

| | | | |
|----------|---------------------------------|----------|------------|
| [_____] | Extended Coverage for: | [Yes/No] | Signature: |
| | ___ Student Only | | |
| | ___ Student and Spouse | | |
| | ___ Student, Spouse, Child(ren) | | _____] |

The above list of insurance benefit(s) identified as applicable to the Policyholder may later be added or deleted by an amendment issued to the Policy.

[Any and all references to "Dependent" apply only if Dependent coverage is elected.]

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Definitions - Major Medical Benefits..... [13]

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[Dental Care Benefits..... [19]]

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Claim Provisions [24]

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ELIGIBILITY, EFFECTIVE AND TERMINATION DATES OF INDIVIDUAL COVERAGE

ELIGIBILITY

Eligible Student means any [international] [and practical training][outbound] [domestic] student, [and] [visiting faculty,] [scholar,] [or] [other persons of similar description] of the Policyholder who [meets all of the following]:

- 1.] is enrolled and actively engaged full-time [, as defined by the Policyholder in accordance with applicable United States law,] in educational activities.
- 2.] is temporarily outside his/her home country or country of regular domicile as a non-resident alien, or a non-domiciled United States citizen with dual citizenship, [in the United States].
- 3.] has a current passport and [applicable] current [student] [B,] [F-1,] [J-1,] [or] [M-1] visa or other non-immigrant visa which allows the individual to enroll in a course of study (non-domiciled United States citizen – passport only).]
- 4.] maintains non-immigrant status under the applicable visa type [according to applicable United States law].

[For purposes of Item 1. above,] eligible students taking a term or semester break (herein referred to as “term break”), annually, in accordance with school policy and while keeping coverage in force are considered Eligible Students engaged in full-time educational activities.

[For schools with a two-semester term system, summer break is the designated term break.] [For schools with a [trimester] [or] [quarter] term system, any [trimester] [or] [quarter] can be taken as the term break, provided only one [trimester] [or] [quarter] is taken per academic calendar year.]

[The following do not count toward fulfilling the full-time status Eligibility requirement:

- 1.] [home study.]
- 2.] [correspondence courses.]
- 3.] [internet courses.]
- 4.] [television courses.]

[International students who have applied for permanent residency in the U.S. in accordance with federal law in effect at the time of enrollment, are not Eligible Students.]

Eligible Dependent means any dependent of an Eligible Student who meets all of the following:

1. is the Eligible Student's lawful spouse or unmarried Child (under age [19] and dependent upon the Eligible Student or the student's spouse for the Child's main support and care);
2. resides with the Eligible Student; [and]
3. is enrolled for coverage under the Policy at the same time the Eligible Student enrolls[.] [.]
4. has a current passport and visa (non-domiciled United States citizen – passport only) [; and]]
5. is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien, or a non-domiciled United States citizen with dual citizenship, [in the United States] [.]

Continued Eligibility for Disabled, Unmarried Child: The Insured Student's disabled, unmarried dependent Child may continue to be an Eligible Dependent Child beyond age [19] if all of the following, additional conditions are met:

1. The Child became disabled before reaching age [19];
2. The Child is incapable of self-sustaining employment because of developmental disability or physical handicap and is chiefly dependent upon the Insured Student for support and maintenance;
3. The student remains insured under this Policy;
4. The Child's premiums, if any, continue to be paid;
5. First proof of incapacity must be given to the Company (at our expense) as soon as possible after the Child reaches age [19]. The Company's approval of such statement is required for the Child to continue eligibility; and
6. The Insured Student provides proof satisfactory to the Company of the Child's disability and dependent status when the Company requests it.

“Child” means an Eligible Student's natural Child; step-Child; adopted Child or a Child Placed For Adoption which means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of the adoption of such Child; the Child's placement with the Eligible Student is considered terminated upon the termination of such legal obligation. When a petition for adoption of a Child is filed by the Insured Individual, dependent coverage for that Child will begin on the date of the filing if such individual applies for coverage within 60 days of the date of the filing. For a newborn adopted Child, dependent coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the Child.

Newborn Infants - Sick Baby Care: A newborn Child of an Insured Student will automatically be an Insured Individual for 90 days from the moment of birth **only** for Covered Expenses incurred which are due directly to Injury or Bodily Infirmary, premature birth, or a congenital condition which exists at birth. In order to continue the coverage of a newborn Child beyond the 90th day following date of birth: (1) notice of the birth of the Child must be provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, must be received by the Company. If (1) and (2) above are not satisfied, coverage of a newborn Child, including any Continuation of Benefits, will terminate 90 days from the date of birth.

Newborn Infants - Well Baby Care: A newborn Child of an Insured Student will be an Insured Individual from the moment of birth if: (1) notice of the birth of the Child is provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, is received by the Company. Covered expenses for the newborn Child will include: (a) Hospital room and board (or nursery) charges, (b) routine Doctor visits while Hospital confined; and (c) circumcision while Hospital confined. Such Covered Expenses for Well Baby Care are payable until the earlier of the date the Mother is discharged from the Hospital or the date the Child is ≥ 5 days old.

EFFECTIVE DATE OF INDIVIDUAL COVERAGE

For Eligible Students:

Provided the Policyholder has paid the required premium for the specific Eligible Student in accordance with the Policy provisions, coverage for that Eligible Student who has enrolled in the plan will be effective:

1. on the first day of the school term for which coverage is applied for if the Eligible Student became an Eligible Student on the first day of the school term and applies within the first 60 days of the school term;
2. on the first day of becoming an Eligible Student if such day is after the first day of the school term, and enrollment is made within 60 days of becoming an Eligible Student;
- [3.] [for an Eligible Student who is eligible for Extended Coverage, 30 days prior to the first day of the school term if the Eligible Student applies for coverage within the first 60 days of the school term;]
4. on the first day an Eligible Student suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
5. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Student or after an Eligible Student suffers an involuntary loss of other coverage; or
6. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

[Extended Coverage means additional days of coverage that are available to a newly enrolled Eligible Student [and his or her Eligible Dependents] who arrive in the [United States] [country in which the student is attending school] prior to the commencement of the student's studies.] Subject to timely application and payment of premium as described above, Extended Coverage will be effective 30 days prior to the first day of the school term. Upon the Eligible Student's graduation or completion of an educational program and in preparation for the resulting departure from the [United States][country in which the student is attending school], coverage for the student [and his or her covered Dependents] will terminate 30 days following graduation or completion of an educational program, provided the student [and his or her covered Dependents] remain[s] in the [United States] [country in which such individual is attending school] during that 30-day period].

[An Eligible student who is covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:

1. the request is made prior to the termination of Extended Coverage; and
2. the premium is promptly paid for the additional 30 days of coverage; and
3. the Insured Student and covered Dependents, if any, remain in the [United States][the country in which the student attended school].]

For Eligible Dependents:

Coverage for an Eligible Dependent of an Eligible Student, who has enrolled in the plan and for whom the Policyholder has paid the required premium, will be effective:

1. the date the Eligible Student's coverage begins with respect to each Eligible Dependent the student has at time of his/her enrollment;
- [2.] [For an Eligible Student's Eligible Dependent under Extended Coverage, 30 days prior to the first day of the school term if the Eligible Student applies within the first 60 days of the school term. See "Extended Coverage" provision for more information.]
3. the date of birth of a natural child, if enrollment is made within 90 days of birth;
4. the date of birth of a Child Placed For Adoption or for which a petition for adoption has been filed, if enrollment is made within 60 days birth;
5. the date a petition for adoption is filed for the adoption of a Child, if enrollment is made within 60 days of such filing.
6. on the first day of the first month following the dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured Student is covered under the Policy;
- [7.] on the first day of the first month following the date the dependent first meets the definition of "Eligible Dependent" if such dependent did not qualify at the time the Insured Student was enrolled under the Policy. Enrollment must be made within 31 days of becoming eligible;]
- [8.] on the first day an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
- [9.] on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Dependent or after an Eligible Dependent suffers an involuntary loss of other coverage; or
- [10.] under special circumstances, the effective date determined by the Company_for all similarly situated eligible persons.

Dependent coverage cannot become effective prior to the Effective Date of Coverage of the Eligible Student.

TERMINATION DATE OF INDIVIDUAL COVERAGE

Coverage for an Insured Individual will automatically terminate on the earliest of the following dates:

1. the date the Policy terminates;
2. the last day of the period for which premium has been timely paid according to Policy provisions;
3. the date the Insured Individual is no longer eligible for coverage; [or]
- [4. For an Insured Individual under Extended Coverage, as described in the "Extended Coverage" provision;]
5. the date requested by the Insured Individual and approved by the Policyholder in writing that is no sooner than 5 days after the date the Company (or its authorized administrator) receives written notice. Any unearned premium will be returned, but returned premium will only be for the number of full months remaining in the unexpired term of coverage; [or][.]
- [6. the date the Insured Individual departs [the United States] for the individual's home country or country of regular domicile.]

PREMIUM

Premium Due Dates: The first premium is due on the effective date. [Future premiums are due each school term on the first day of the school term.] [Future premiums are due each [month] on the [first day] of the [month].] The Policyholder shall submit to the Company for each period of coverage a roster of and premiums for the Insured Individuals.

Grace Period: If premium is not paid within 30 days after the due date, the Policyholder shall have 31 days of grace to pay the premium. The policy shall remain in force during such time. If the premium is not paid within this 31 day period, the Policy will cease to be in effect and coverage will terminate retroactively to the day before the due date.

Premium Rates: The Company may change the premium rates on or after the first Policy anniversary, but not more often than once in any 6 (six) month period. Notwithstanding, the Company may change the premium rate on any date the Policy is amended.

The required premium rates under the Policy at its effective date are:

[Major Medical Benefits [(includes Dental Care)]

| | | |
|-----------------------------|----------------|--------------|
| Eligible Student | \$ [] [*] | [per month] |
| Eligible Student and Spouse | \$ [] [*] | [per month] |
| Each Eligible Child | \$ [] [*] | [per month]] |

[* Includes [\$4.00] per student per month for administration of extended coverage.]

[Dental Care Benefits

| | | |
|-----------------------------|-----------|--------------|
| Eligible Student | [\$] | [per month] |
| Eligible Student and Spouse | [\$] | [per month] |
| Each Eligible Child | [\$] | [per month]] |

[Accidental Death and Dismemberment Coverage

| | |
|------------------|--|
| Eligible Student | \$ [0.00] per \$1,000 of Maximum Amount per month] |
|------------------|--|

[MAJOR MEDICAL BENEFITS

Each Insured Student covered under the [International] [Outbound][Domestic] Policy has a Major Medical Benefit maximum [per Accident or Sickness] *(remove for high deductible)* of [\$75,000]. [Each Eligible Dependent covered under the [International] [Outbound] [Domestic] Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$50,000].] [However, in no event will the benefit maximum for all Accidents and Sickness exceed [\$50,000] *(remove for high deductible)* in any consecutive 12-month period per Insured Individual.]

DEDUCTIBLE

Covered Expenses will be paid at [100%] after satisfying the following Deductible amounts:

1. With respect to the Insured Student[:] *(delete colon for outbound plans)*
 - [a.] If the educational institution at which the student attends has a Student Health Center:
 - i. there will be [no] [\$15.00] Deductible for Covered Expenses from the Student Health Center;
 - ii. there will be a [\$20.00] Deductible per Accident or Sickness if the Insured Student is referred outside the Student Health Center by a Student Health Center Physician;
 - iii. there will be a [\$50.00] Deductible per Accident or Sickness if the Insured Student does not visit the Student Health Center first for diagnosis and treatment of a covered Injury or Bodily Infirmary.]
(Use for International or domestic with regular deductible plan)
 - [a.] There will be a [\$50.00] Deductible per Accident or Sickness.] *(Use with Outbound plans)*
 - [b.] If the educational institution at which the student attends does not have a Student Health Center, there will be a [\$50.00] Deductible per Accident or Sickness.] *(Use for International or domestic with regular deductible plan)*
 - [a.] There will be no Deductible for Covered Expenses from the Student Health Center.
 - b. There will be a [\$500.00] Deductible for Covered Expenses not incurred at a Student Health Center in any consecutive 12 month period.]. *(Use for high deductible plan)*
- [2.] With respect to the Insured Individual who is the Eligible Dependent, there will be a [\$50.00] Deductible per Accident or Sickness.] *(Use with regular deductible plan)*
- [2.] With respect to the Insured Individual who is the Eligible Dependent, there will be a [\$500.00] Deductible per Accident or Sickness not to exceed [\$500.00] in any consecutive 12 month period.]. *(Use with high deductible plan)*
3. With respect to any Insured Individual, there will be an additional [\$50.00] Deductible per Sickness before a benefit is payable for Covered Expenses which are incurred for visits to a Hospital emergency room. Such Deductible shall not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.

[Maximum Family Deductible

In no event will the Family Deductible amount for Covered Expenses exceed [\$1,000.00] in any consecutive 12 month period for an Insured Student and Eligible Dependents.]

INSURING CLAUSE

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable for a Covered Expense if:

1. the Deductible requirement, if any, is met;
2. the expense is incurred due to a covered Injury or Bodily Infirmary;
3. the Insured Individual has not exceeded the Policy's Major Medical Benefits maximums.]

[MAJOR MEDICAL BENEFITS

Each Insured Student covered under the [International] [Outbound][Domestic] Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$75,000]. [Each Eligible Dependent covered under the [International] [Outbound] [Domestic] Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$50,000].] [However, in no event will the benefit maximum for all Accidents and Sickness exceed [\$50,000] in any consecutive 12-month period per Insured Individual.]

COPAYMENT BENEFIT SCHEDULE

Benefits for Covered Expenses will be paid as follows:

1. For charges of a Doctor, Covered Expenses will be paid at:
 - a. [100%], [with][without] application of a [\$15.00] Copayment for services provided at a Student Health Center.
 - b. [100%], after the Insured Individual pays a [\$25.00] Copayment per visit for services provided by a Participating Provider.
 - c. [80%], after the Insured Individual pays a [\$35.00] Copayment per visit for services provided by a provider who is not a Participating Provider.
2. For charges incurred at a Hospital (includes outpatient and inpatient services), Covered Expenses will be paid at:
 - a. [100%], after the Insured Individual pays a [\$50.00] Copayment per inpatient Hospital admission or outpatient visit for services provided by a Participating Provider.
 - b. [80%], after the Insured Individual pays a [\$100.00] Copayment per inpatient Hospital admission or outpatient visit for services provided by a provider who is not a Participating Provider.
3. For charges incurred at a Hospital for emergency room care, Covered Expenses will be paid at:
 - a. [100%], after the Insured Individual pays[:]
 - a [\$50.00] Copayment per visit for services provided by a Participating Provider [for treatment of an Accident].
 - [- a [\$100.00]** Copayment per visit for services provided by a Participating Provider for treatment of a Sickness.]
 - b. [80%]*, after the Insured Individual pays[:]
 - a [\$125.00] Copayment per visit for services provided by a provider who is not a Participating Provider [for treatment of an Accident].
 - [- a [\$175.00]** Copayment per visit for services provided by a provider who is not a Participating Provider for treatment of a Sickness.]

* If it was not reasonably possible to get to a Participating Provider for Emergency Care, the Participating Provider level of payment will be payable.

** This Copayment will not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.

Benefits will be paid at these levels unless stated otherwise in the Covered Expense section or Exceptions and Exclusions section. The Insured Individual will not be reimbursed for a Copayment.

Emergency means an Injury or Emergency Medical Condition that reasonably requires an Insured Individual to seek immediate medical care within [48] hours after the Injury or the onset of the Emergency Medical Condition.

Emergency Care means covered services furnished or required to screen and stabilize an Emergency Medical Condition, which may include but shall not be limited to, health care services that are provided in a Hospital's emergency facility.

Emergency Medical Condition means the sudden, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required. Emergency Medical Conditions may include, but are not limited to:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. inadequately controlled pain; or
5. with respect to a pregnant woman having contractions:
 - a. inadequate time to effect a safe transfer to another Hospital before delivery; or
 - b. a transfer to another Hospital may pose a threat to the health or safety of the woman or unborn Child.

Benefits For Services of a Participating Provider

The Policy provides different levels of benefits and copayments depending on whether or not the Insured Individual uses the services of a Participating Provider. The Insured Individual is free, however, to use the provider of his or her choice. If the Insured Individual selects a Participating Provider, the Policy may pay benefits, if any, to the provider of service.

[Out-of-Pocket Expense Maximum

When [\$2,000] [\$3,000] in Out-of-Pocket Expenses has been paid by any Insured Individual during a calendar year, the [80%] level of benefit payments for services will automatically increase to 100% for any additional eligible Covered Expense incurred by that same Insured Individual during the remainder of that calendar year and Copayment charges will no longer apply.

An Out-of-Pocket Expense is the [20%] share of any otherwise eligible (Reasonable and Customary) expense and Copayment amounts that an Insured Individual pays.]

INSURING CLAUSE

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable for a Covered Expense if:

- (1) the Copayment amount, if any, is met;
- (2) the expense is incurred due to a covered Injury or Bodily Infirmary;
- (3) the Insured Individual has not exceeded the Policy's Major Medical Benefit maximums.]

COVERED EXPENSES

Covered Expense means only the expense actually incurred for medical care, treatment, services, and supplies by an Insured Individual which are Medically Necessary and meet the following conditions:

1. are prescribed by a Doctor for the therapeutic treatment of a covered Injury or Bodily Infirmary;
2. are not excluded by any provisions contained in the Policy; and
3. are not more than the Reasonable and Customary charges (as defined by the Policy) [with respect to out of network charges].

To determine if medical care and supplies and the expense charged are Reasonable and Customary, the Company will consider the medical care or supplies usually given and the fees usually charged for a like Injury or Bodily Infirmary in that Area.

[If the Insured Individual uses a Participating Provider, Covered Expense means the agreed upon rate set between the Company and such provider for medical services which meet all of the above standards.]

The Company will consider each Covered Expense to be incurred on the date the medical care or supply is received. Covered Expenses under the Policy are limited to the following:

1. charges for diagnosis and treatment by a Doctor, registered nurse (not a Close Relative of or same legal residence as the Insured Individual).
2. charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges.
3. charges by a Hospital for outpatient medical care received on an outpatient basis and outpatient medical supplies which are used on the premises of a Hospital.
4. charges for home health care performed by a licensed home health agency when prescribed by a Doctor in lieu of Hospital services, provided the Hospital services would have been Covered Expenses under the Policy.
5. charges for laboratory, x-ray, and other diagnostic examinations.
6. charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay up to [100%] of charges for such drugs used on an inpatient basis [or dispensed by a Student Health Center] and [50%] of charges for such drugs [not dispensed by a Student Health Center Physician and] which are used for outpatient treatment.
- [[7.] charges for prescription oral contraceptives dispensed by a Student Health Center or a licensed pharmacist; the Policy will pay up to [50%.]
- [[8.] charges for prescription contraceptive devices.]
9. charges for emergency professional ambulance service by ground or air to a Hospital [up to a maximum benefit of [\$500.00]] (see Medical Evacuation Benefit below for air service to an Insured Individual's home country).

10. charges for the following types of orthopedic or prosthetic devices or Hospital equipment:
- a. man-made limbs or eyes for the replacing of natural limbs or eyes;
 - b. casts, splints or crutches;
 - c. purchase of a truss or brace;
 - d. oxygen and rental of equipment for giving oxygen;
 - e. rental of a wheelchair or Hospital bed;
 - f. rental of dialysis equipment and supplies;
 - g. colostomy bags and ureterostomy bags; and
 - h. two external post-operative breast prostheses.
- The Policy will not cover rental charges for equipment in excess of the purchase price of the equipment.

[11.] charges for one routine baseline or screening mammogram in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation.

[[12.] charges for one routine pap smear in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation.]

- [13.] charges for colorectal cancer screening examinations and laboratory tests for an Insured Individual:
- a. who is 50 years of age or older;
 - b. who is less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society guidelines;
 - c. regardless of age, if the person is experiencing symptoms of colon cancer.

[[14.] charges for an elective abortion to a maximum benefit of [\$500] per occurrence.]

- [15.] charges for anesthesia and facility charges in connection with dental procedures performed in a Hospital for an Insured Person who is:
- a. under 7 years of age, if 2 Dentists certify that the Child has a significantly complex dental condition; or
 - b. any age, with a serious medical or physical condition; or
 - c. any age, if a Physician determines that the person has a significant behavioral problem.
- This does not include coverage of the dental procedure. [If the dental procedure is an eligible covered dental expense, then it will be covered under the Policy's Dental Care Benefit.]

[16.] charges for treatment of loss or impairment of speech or hearing, when performed by a licensed speech pathologist or audiologist. This does not include coverage of hearing instruments or devices. The maximum Benefit is [\$500] in any consecutive 12-month period. The maximum benefit per visit after satisfaction of the applicable [Copayment][Deductible] is [\$50] for the first visit and [\$25] thereafter. Charges in excess of these maximums shall not be included as Covered Expenses under the Policy.

Physiotherapy Expenses: Covered Expenses for Physiotherapy (as defined below) which are incurred while not confined in a Hospital and which are billed by a Doctor or physiotherapist shall not exceed the maximum amounts shown below. Charges in excess of these maximums shall not be included as Covered Expenses under the Policy.

The maximum Physiotherapy Benefit is [\$500] in any consecutive 12-month period. The maximum benefit per visit after satisfaction of the applicable [Copayment][Deductible] is [\$50] for the first visit and [\$25] thereafter.

"Physiotherapy," under the Policy, means treatment of Bodily Infirmary or Injury by the use of physical means including, but not limited to, air, heat, light, water, electricity, massage, manipulation, acupuncture or active exercise.

Pregnancy Expenses: Covered Expenses for pregnancy are payable on the same basis as Covered Expenses for any other Bodily Infirmary [with respect to an Insured Student or eligible spouse. No benefits are payable for any expenses which relate to the pregnancy of an eligible Child].

Pregnancy coverage shall also include post-delivery inpatient Hospital care for a mother and her newly born Child in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists which is ≥ 48 hours following a vaginal delivery, or ≥ 96 hours following a caesarean section. A decision to shorten the length of stay may be made by the attending Physician in consultation with the mother.

Post-Mastectomy Coverage: Coverage of a Medically Necessary mastectomy will also include coverage of the following:

1. physical complications during any stage of the mastectomy, including lymphedemas;
2. reconstruction of the breast;
3. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
4. two external breast prostheses.

Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

Inherited Metabolic Diseases: Benefits for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas for use in the treatment of phenylketonuria (PKU) will be considered a Covered Expense provided:

1. such food products are prescribed as medically necessary for the therapeutic treatment of PKU; and
2. the products are administered under the direction of a physician; and
3. the cost of such products exceeds $\geq \$2,400$ per year.

Benefits are subject to deductibles, coinsurance, copayments and maximums on the same basis as other similar Benefits under the Plan.

In Vitro Fertilization: Coverage will be provided for in vitro fertilization subject to the following conditions:

1. The insured female's oocytes must be fertilized with the sperm of her spouse;
2. (a) The Insured Student and his/her spouse have had a history of unexplained infertility of at least 2 years; or
(b) the infertility is associated with one or more of the following medical conditions:
 - i. Endometriosis;
 - ii. Exposure in utero to Diethylstilbestrol (DES);
 - iii. Blockage or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - iv. Abnormal male factors contributing to the infertility; and
3. The insured female has been unable to obtain successful pregnancy through a less costly infertility treatment covered by this policy.

The in vitro fertilization procedures must be performed at a medical facility licensed or certified by the Arkansas Department of Health as an in vitro fertilization clinic. If no such facility is licensed or certified in Arkansas or no such licensing program is operational, then coverage will be extended for any procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Cyropreservation (the procedure whereby embryos are frozen for later implantation) is an eligible expense within these in vitro fertilization benefits.

A pre-existing condition limitation of 12 months applies for these in vitro fertilization Benefits. This in vitro fertilization Benefit is subject to a lifetime maximum of $\geq \$15,000$.

Child Health Supervision Services: Coverage will be provided to dependent Children for "Child Health Supervision Services" from birth through 18 years of age at the following intervals:

20 visits will be included at approximately the following age intervals:

| | |
|-----------|----------|
| birth | 3 years |
| 2 weeks | 4 years |
| 2 months | 5 years |
| 4 months | 6 years |
| 6 months | 8 years |
| 9 months | 10 years |
| 12 months | 12 years |
| 15 months | 14 years |
| 18 months | 16 years |
| 2 years | 18 years |

"Child Health Supervision Services" means the periodic review of a Child's physical and emotional health provided by or under the supervision of a single Physician, during the course of one visit, including medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests, all in keeping with prevailing medical standards.

Coverage for immunization services is not subject to deductibles, coinsurance and Benefit Maximums. All other children's preventive health care services are subject to the same deductibles, coinsurance and Benefit maximums as other similar coverage in the Plan.

[Musculoskeletal Disorders Benefit: Benefits for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder will be considered a Covered Expense.

Benefits will be payable for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology on the same basis as any other musculoskeletal disorder in the body whether prescribed or administered by a Physician or Dentist.]

[Hospice Care Benefit: Charges for hospice care when prescribed by a Doctor in lieu of Hospital services, provided the Hospital services would have been Covered Expenses under the Policy, and subject to the following:

- the Insured Individual's must Physician recommend in writing on or before hospice care is started
- the Insured Individual must elect (in writing to Us) to follow the Physician's proposed treatment plan;
- such care must be administered by a licensed Hospice Care Facility;
- coverage is limited to a maximum of 6 months, with an additional 6 months of care in cases where the patient is facing imminent death or is entering remission, if certified in writing by the attending Physician.

Coverage under this provision ends if the Insured Individual elects (in writing) to discontinue Hospice care.

Hospice Care Benefits are not payable for:

- services provided by persons who do not regularly charge for their services;
- counseling which is not provided as part of the Hospice care plan;
- services provided by homemakers, caretakers and the like;
- funeral expense;
- treatment intended to cure the terminal illness.]

[Mental and Nervous Disorders, Alcoholism, Drug Dependency Coverage: Covered Expenses are payable for treatment of Injury or Bodily Infirmity from a Mental or Nervous Disorder, alcoholism or drug dependency, up to (a) an aggregate limit of [30] days of inpatient care in any consecutive 12 month period payable after any applicable [Deductible] [Copayment], and (b) outpatient treatment up to a benefit limit of [10] outpatient visits in any consecutive 12 month period, payable after any applicable [Deductible] [Copayment].

Interscholastic and Intercollegiate Sports Benefit: Benefits will be payable up to a maximum benefit of [\$25,000] per Accident arising out of practice for or participation in interscholastic or intercollegiate sports.

Medical Evacuation Benefit: Subject to prior approval from the Company or its authorized representative, as an additional benefit, the Policy will cover up to a maximum benefit of [\$50,000] of reasonable charges for air evacuation of an injured or sick Insured Individual [and a Health Care Provider or Escort if directed by the attending Doctor,] to the individual's [Home City] [home country or country of regular domicile], provided air evacuation:

1. is upon the attending Doctor's written certification;
2. results from a covered Injury or Bodily Infirmary; and
3. does not occur prior to the benefit approval.]

[“**Home City**” means the location within the United States where the Insured Individual intends to reside following medical evacuation.]

Repatriation Benefit: Subject to prior approval from the Company or its authorized representative, as an additional benefit, the Policy will cover up to a maximum benefit of [\$25,000], in the aggregate, reasonable expenses that are incurred in connection with the preparation and transportation of the body of a deceased Insured Individual to the individual's place of residence [within the United States where the Insured Individual is to be buried] [in the individual's home country]. This benefit does not include transportation expenses of any person accompanying the body. Prior approval from the Company is required for this benefit.]

Continuation Benefits: Covered Expenses incurred, while Hospital Confined, will be payable up to a maximum benefit of [\$5,000 or 13 weeks], whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's Insurance terminates. Benefits payable under this provision will terminate if an Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for medical care, treatment, supplies, or services not listed in the Covered Expense section;
- [2.] for medical care, treatment, supplies, or services for the Insured Individual in his/her home country or country of regular domicile; [except the Policy will cover Accident or Sickness for Outbound students up to a maximum benefit of [\$5,000] in any consecutive 12 month period, if the Insured Individual is returning to the United States due to the Accident or Sickness and the Accident occurred or Sickness commenced while the Insured Individual was insured under this Policy;]
- [3.] due to a pre-existing Injury or Bodily Infirmary or complication thereof. A pre-existing Injury or Bodily Infirmary is one where the Insured Individual: (a) has consulted a Doctor; (b) had medicine prescribed; or (c) is receiving or has received medical care for that Injury or Bodily Infirmary in the [6] months prior to the Insured Individual's Effective Date of Coverage under the Policy.

However, benefits will be payable for a pre-existing Injury or Bodily Infirmary after the Insured Individual's coverage has been in force for [12] consecutive months.

Modification to Pre-Existing Exclusion: The Policy will not impose pre-existing limitations on an Eligible Student or Eligible Dependent who enrolls for coverage as a Federally Eligible Individual. If an Eligible Student has a dependent that does not meet the Federally Eligible Individual definition, the Eligible Dependent will be subject to the pre-existing limitations as defined in the Policy.

The Policy will not impose pre-existing limitations on a Child who was covered by Creditable Coverage within 31 days of birth, adoption or Placement for Adoption, provided the Child has not subsequently been without Creditable Coverage for more than [62] days.

- [4.] for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, [abortion (except spontaneous and non-elective abortion),] circumcision (except as covered under the Newborn Infants - Well Baby Care provision), learning disabilities, immunizations, obesity, allergy tests, vitamins, and antitoxins;
- [5.] for routine physical or health examinations, except as provided in the Covered Expenses section;
- [6.] for any care in connection with the teeth, gums, jaw, or structures directly supporting the teeth; myofacial pain; or temporomandibular joint dysfunction, except the Policy will cover injury to natural teeth resulting from an Injury up to a maximum benefit of [\$100] per tooth [and an overall maximum benefit of [\$500]] per Accident;
- [7.] in excess of the Reasonable and Customary charge;
- [8.] for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from:
 - a. an Injury;
 - b. a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or
 - c. a mastectomy (refer to the Post-Mastectomy Coverage provision);
- [9.] for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
- [10.] for hearing aids, eye glasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery;

- [11.] for Injury or Bodily Infirmary if covered to any extent under: any occupational benefit plan; Worker's Compensation or similar law; medical payments under individual automobile insurance (except for no-fault auto insurance);
- [12.] [for birth control, including surgical procedures and devices;]
[for birth control devices and surgical procedures;]
- [13.] for Injury arising out of practice for or participation in professional sports;
- [14.] for medical care, treatment, supplies or services in excess of [\$25,000] per Accident arising out of practice for or participation in interscholastic or intercollegiate sports;
- [15.] for medical care, treatment, services, and supplies for which no charge is made or no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
- [16.] for intentionally self-inflicted Injury or Bodily Infirmary, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmary resulting from taking part in the commission of an assault or felony;
- [17.] for diagnosis, treatment, and all other care related to infertility, except as provided in the Covered Expenses section under the In Vitro Fertilization benefit Provision;
- [18.] Transcutaneous Electrical Nerve Stimulation (TENS) units;
- [19.] for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
- [20.] for Injury or Bodily Infirmary from a Mental or Nervous Disorder, alcoholism or drug dependency; except as listed in the Covered Expense section;
- [21.] for Injury or Bodily Infirmary resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license;
- [22.] for Injury or Bodily Infirmary resulting from an act of war (declared or undeclared), insurrection, terrorism, participation in the military service of any country, or participation in a riot or civil disorder;
- [23.] for medical care, treatment, services, or supplies normally given without charge and provided by employees or Doctors employed by, under contract with, or retained by the Policyholder;
- [24.] for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy.

DEFINITIONS - Major Medical Benefits

Unless separately defined herein, wherever used in the Policy:

1. **Accident** means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a unforeseen force or event to that Insured Individual and independent of any other such force or event.
2. **Average Semiprivate Charge** means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.
3. **Bodily Infirmary** means a Medical Condition of an Insured Individual caused by, arising out of, resulting from or the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual.
4. **Close Relative** means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.
- [[5.] **Copayment** means that portion of a Covered Expense an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion.]
- [6.] **Covered Expense** – see Covered Expense Section of the Major Medical Benefits section of the Policy.
- [7.] **Creditable Coverage** means any of the following coverage that an Insured Individual had prior to enrollment under the Policy:
 - a. an employee group health plan;
 - b. health insurance coverage, individual or group, including coverage through a Health Maintenance Organization (HMO);
 - c. Medicare;
 - d. Medicaid;
 - e. TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families;
 - f. a medical care program of the Indian Health Service or of a tribal organization;
 - g. a state health risk pool;
 - h. a health plan offered under the Federal Employee Health Benefits Program;
 - i. a public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government or a foreign country, that provides health coverage to individuals who are enrolled in the plan;
 - j. a health benefit plan established by the Peace Corps Act;
 - k. a State Children's Health Insurance Program (S-CHIP).

Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under this Policy to group coverage by another plan. Coverage provided by this Policy is not considered Creditable Coverage by this or other student health policies. Certificates of Creditable Coverage will be issued to individuals terminating student status and remaining in the United States as set forth in the federal Health Insurance Portability and Accountability Act (HIPAA).

Days of Creditable Coverage that occur before a Significant Break in coverage do not count towards satisfaction of the pre-existing limitation. A Significant Break in Coverage means a period of 63 days during all of which the individual does not have Creditable Coverage.

[8.] **Deductible** means the dollar amount, specified in the Policy, of a Covered Expense which must be incurred as an out-of-pocket expense by each Insured Individual per Accident or Sickness before benefits are payable under the Policy.

[9.] **Doctor or Physician** means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual. It will also include any other licensed practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which benefits are provided under the Policy.

[10.] **Federally Eligible Individual** means an individual who meets all of the following:

- a. the individual has at least 18 months of Creditable Coverage as of the date on which the individual seeks coverage under the Policy
- b. the individual's most recent prior Creditable Coverage was under one of the following types of plans or an insurance plan offered in connection with any of these plans:
 1. an employee group health plan;
 2. a governmental plan; or
 3. a church plan;
- c. the individual is not eligible for coverage under another group health plan, Medicare or Medicaid;
- d. the individual does not have other health insurance coverage;
- e. the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and
- f. if the individual has the option to continue coverage under a COBRA continuation or similar State program, such coverage was elected and exhausted.

[11.] **Hospital** means only such a place that meets all of the following conditions:

- a. operates as a Hospital pursuant to law for the care and treatment of sick or injured individuals;
- b. has permanent and full-time care for bed patients;
- c. has a staff of one or more licensed Physicians available at all times;
- d. provides 24-hour a day care by registered nurses on duty or call;
- e. has surgical facilities; and
- f. is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a Hospital used as such.

Hospital also means a "free standing surgical center" that meets all of the following standards:

- a. is a licensed public or private place;
- b. has an organized medical staff of Doctors;
- c. has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care; and
- d. has R.N. services when a patient is in the facility.

Hospital also means such place operated mainly to treat a Mental or Nervous Disorder if it meets the standards below:

- a. is a Hospital, psychiatric Hospital or outpatient psychiatric center licensed by the Arkansas Health Department; or
- b. is a Community Mental Health Center certified by the Arkansas Department of Human Services, Division of Mental Health Services.

[12.] **Hospital Admission** means a single period of Hospital confinement or outpatient care for one or more causes.

- [13.] **Injury** means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual.
- [14.] **Insured Individual:** means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements.
- [15.] **Insured Student** means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
- [16.] **Intensive Care Unit** means a unit exclusively reserved for critically and seriously sick or injured patients requiring constant audio-visual observation, as prescribed by the attending Doctor, which provides room and board, trained and qualified personnel whose duties are primarily confined to such unit, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the Hospital's facilities.
- [17.] **Medical Condition** means any bodily or mental disease, illness or Injury requiring treatment by a Doctor.
- [18.] **Medically Necessary** means only care and treatment the Company determines meets all of the following conditions:
- a. the care and treatment is Appropriate, given the symptoms and is consistent with the diagnosis, if any. **"Appropriate"** means that the type, level and length of service and setting are needed to provide safe and adequate care and treatment;
 - b. it is rendered in accordance with generally accepted medical practice and professionally recognized standards;
 - c. it is not treatment that is generally regarded as experimental or unproven; and
 - d. it is specifically allowed by the licensing statutes which apply to the provider who renders the service.
- [19.] **Mental or Nervous Disorder** means neurosis, psychoneurosis, psychosis, or mental disease or disorder of any kind resulting from any cause including, but in no way limited to, biological cause.
- [[20.] **Participating Provider** means a Doctor or a Hospital that agrees to provide Medically Necessary care and treatment at set rates.]
- [21.] **Policy** means the Policy including all amendments, riders and endorsements.
- [22.] **Policyholder** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.
- [23.] **Reasonable and Customary** means, with regard to charges for medical services or supplies, the lowest of:
- a. the usual charge by the provider for the same or similar medical services or supplies;
 - b. the usual charges of most providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies; or
 - c. the actual charge for the services or supplies.
- "Area"** means the location where the medical care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of medical care or supplies.

- [24.] **Sickness** means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from or the cause of one period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. "One Period" commences with the onset of the initial (or only) Bodily Infirmary that occurred during the Sickness, and ends when the Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmary that occurred during that Sickness for ninety (90) consecutive days.
- [25.] **Student Health Center** means an ambulatory care facility affiliated or contracted with the Policyholder that at a minimum maintains a staff consisting of a nurse director/nurse practitioner, staff nurses and a staff physician or an arrangement with a physician to perform office visits.][**Student Health Center** [means][also includes] [a designated Take Care Health Center or other similar facility specified by the educational institution if such institution does not have a designated Student Health Center.]

COORDINATION OF BENEFITS

If this is not the Insured Individual's only plan coverage, the benefits payable under this Policy, and any other group plan for the Allowable Expenses incurred during any Benefit Determination Period will be coordinated so that the combined benefits paid or provided by all plans will not exceed 100% of such Allowable Expenses.

The Insured Individual must inform the Company if he/she has other coverage (for example, through a spouse's or parent's employer); and give consent to the release of information so that this provision may be used. The Insured Individual should first file his/her claim with the primary plan (as determined below). When the claim is paid, the Insured Individual should send a copy of the charges and a copy of the Explanation of Benefits Statement from the first plan to the secondary plan (as determined below). This will accelerate the processing of a claim.

One Plan will be determined to be primary (using the rules below). The primary plan pays its full benefits first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

A plan is primary when:

1. the plan does not have a COB provision;
2. the plan designates itself as an "excess" or "always secondary" plan; or
3. if both plans have a COB provision and, under the rules below, it is determined to be primary.

When both plans have a COB provision, the order in which the plans provide benefits is determined using the first of the following rules which applies:

1. Principal Covered Person/dependent. The plan that covers the person as a Principal Covered Person is primary. If an Insured Individual is also covered by Medicare, the plan covering the person as a Principal Covered Person is primary, the plan covering the person as a dependent of a Principal Covered Person is secondary, and then Medicare.
2. Dependent Children.
 - a. If the parents are not separated or divorced, the plan that covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan that covered the parent longer is primary. If the other plan does not have the "birthday rule", the rule in the other plan will determine the primary plan.
 - b. If the parents are separated or divorced, the plan which covers the natural parent with custody is primary; followed by the plan which covers the step-parent who has married the natural parent with custody; and finally, the plan which covers the natural parent without custody.

However, if the court decrees one of the parents responsible for health care expenses, the plan that covers that parent is primary.

If the decree names the parent other than the natural parent with custody, the Company must be notified and have actual knowledge of those terms. Any benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and third, respectively.

If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. Continuation coverage. Continuation coverage provided under either federal or state law is secondary. If the other plan does not have this rule, this rule is ignored.
4. Length of coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary.

If this Plan is determined to be secondary, benefits payable under this Policy will be reduced so that the total benefits provided by all plans during a claim determination period are not more than the total Allowable Expenses for the Insured Individual. The Company will use the amount by which benefits have been reduced to pay Allowable Expenses, not otherwise paid, which were incurred during the claim determination period and have been submitted for that person.

The actual benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Policy will never exceed the amount that would have been paid if there were no other plans involved. If benefit payments under this Policy are reduced by COB, only the reduced amounts will be charged against the Insured Individual's plan maximums.

If during Coordination of Benefits, payments are made in error, the plans will have the right to adjust payments among themselves. Such payments satisfy the Company's liability. If a claim is overpaid under this Policy, the Company has the right to recover such overpayments from any person for, to whom, or with respect to whom such payments were made, any other insurance company, or any other organization.

Definitions

An "**Allowable Expense**" is the Reasonable and Customary cost for any necessary medical, dental or health care service which is covered (at least in part) by one of the plans. If a health plan provides services (rather than cash payments) a dollar value will be assigned in order to use this provision.

When the primary plan penalizes an Insured Individual for not complying with plan provisions, such as failing to pre-certify, the amount of the reduction is not considered an Allowable Expense.

[A "**Benefit Determination Period**" means from [January 1] of one year to [December 31] of the [same] [next] year.]

A "**plan**" as used in this provision, is any of the following that provide health benefits or services:

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;
3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. government plans, except Medicaid;
6. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
7. no-fault auto insurance on an individual basis, except where not allowed by the state in which this Plan is issued;
8. single or family subscribed plans issued under a group or blanket type plan;

but the definition of plan shall not include:

1. hospital indemnity type plans;
2. school accident-type coverage.]

DENTAL CARE BENEFITS

IMPORTANT NOTICE: The DENTAL CARE BENEFITS only apply to Policy BLK-4554-[XXX] [(Reissued)], if it is so specified in the POLICY SCHEDULE or otherwise added by Amendment.

Each Insured Individual covered under the [Outbound] [Domestic] [International] Policy has a Dental Care Benefits calendar year maximum of [\$1,500].

| Services | The Plan Will Pay | Deductible Applies |
|---------------------------------|------------------------------|-------------------------------|
| [Preventive and Diagnostic Care | [80%] | [Yes/No]] |
| [Basic Dental Care | [50%] | [Yes/No]] |
| [Oral Surgery | [50%] | [Yes/No]] |

When an Insured Individual incurs Covered Dental Care Expenses exceeding the Deductible, benefits will be payable for those expenses up to the calendar year maximum and benefit percentages shown above.

DEDUCTIBLE

The **Deductible**, means the dollar amount of a Covered Dental Care Expense which must be incurred as an out-of-pocket expense by each Insured Individual before benefits are payable under the Policy and will be applied as follows:

With respect to any Insured Individual, the Deductible equals Covered Dental Care Expenses in the amount of [\$25] per Calendar Year.

INSURING CLAUSE

Subject to the exclusions, limitations, and all other provisions of the Policy, Dental Care Benefits are payable for a Covered Dental Care Expense if:

1. the Deductible requirement, if any, is met;
2. the expense is incurred while insured for this coverage;
3. the Insured Individual has not exceeded the Policy's Dental Care Benefits maximum.

COVERED DENTAL CARE EXPENSE

Covered Dental Care Expense means only the expense actually incurred for dental care, treatment, services, and supplies by an Insured Individual which are Medically Necessary and meet the following conditions:

1. are performed by a Dentist or a licensed dental hygienist acting under the supervision and direction of a Dentist;
2. are not excluded by any provisions contained in the Policy; and
3. are not more than the Reasonable and Customary charges (as defined by the Policy).

To determine if dental care and supplies and the expense charged are Reasonable and Customary, the Company will consider the dental care or supplies usually given and the fees usually charged for like dental care in that Area.

The Company will consider each Covered Dental Care Expense to be incurred on the date the dental care or supply is received. Covered Dental Care Expenses under the Policy are limited to the following:

- [1. Preventive and Diagnostic Care which means:
 - a. initial oral examination;
 - b. clinical oral exams, but not more than [one] in [six] consecutive months;
 - c. emergency oral exam;
 - d. x-ray exams:
 - i. panorex film, but not more than [one] in [36] consecutive months;
 - ii. full mouth x-ray, but not more than [one] in [36] consecutive months;
 - iii. individual periapical x-rays; and
 - iv. bitewing x-rays; but not more than [one] in [six] consecutive months;
 - e. dental prophylaxis, but not more than [one] in [six] consecutive months;
 - f. topical application of fluoride for an eligible Child, but not more than [one] in [six] consecutive months.]
- [[2.] Basic Dental Care which means care and supplies for fillings (amalgams).

The Policy will **not** pay benefits for Basic Dental Care expenses incurred within the first 6 months after an Insured Individual becomes covered for this benefit.]

- [[3.] Oral Surgery which means care and supplies for:
 - a. extractions of erupted and unerupted (impacted) teeth;
 - b. crowns;
 - c. root canals therapy (endodontic care).

The Policy will **not** pay benefits for Oral Surgery expenses incurred within the first [12] months after an Insured Individual becomes covered for this benefit.]

DENTAL CARE EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for Dental care or supplies which are not included under Covered Dental Care Expense;
- [2.] for Dental care or supplies furnished outside the United States;]
- [3.] in excess of Reasonable and Customary charge;
- [4.] for Injury resulting from an act of war (declared or undeclared), insurrection, terrorism, participation in the military service of any country, or participation in a riot or civil disorder;
- [5.] for dental care, treatment, services, and supplies for which no charge is made or no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
- [6.] for Injury if covered to any extent under: any occupational benefit plan; Worker's Compensation or similar law; dental payments under individual automobile insurance (except for no-fault auto insurance);
- [7.] for dental care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy;
- [8.] for intentionally self-inflicted Injury or Injury resulting from taking part in the commission of an assault or felony;
- [9.] for Dental care or supplies payable under another part of the Policy;
- [10.] for charges incurred after the Insured Individual is no longer covered for this Dental Care Benefit;
- [11.] for overdentures and associated procedures;
- [12.] for cosmetic procedures;
- [13.] for denture duplication;
- [14.] for the replacement of bridges, full or partial dentures, crowns, inlays or onlays that can be repaired and restored to natural function;
- [15.] for implants;
- [16.] for the replacement of (a) lost or stolen appliances, or (b) orthodontic retainers;
- [17.] for athletic mouthguards;
- [18.] for precision or semi-precision attachments;
- [19.] for sealants;
- [20.] for plaque control;
- [21.] for acid etch;
- [22.] prescription or take-home fluoride;
- [23.] for oral hygiene instructions; and for (a) the completion of a claim form; (b) broken appointments; or (c) diagnostic photographs; and
- [24.] for procedures that are begun, but not completed.

DEFINITIONS - Dental Care Benefits

Unless separately defined herein, wherever used in the Dental Care Benefits section of the Policy:

1. **Close Relative** means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.
2. **Dentist** means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.
3. **Injury** means an accidental dental injury sustained by an Insured Individual which results directly from an accident which occurs independent of any and all other causes.
4. **Insured Individual:** means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements.
5. **Insured Student** means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
6. **Medically Necessary** means only care and treatment the Company determines meets all of the following conditions:
 - a. the care and treatment is Appropriate given the symptoms and is consistent with the diagnosis, if any. **"Appropriate"** means that the type, level and length of service and setting are needed to provide safe and adequate care and treatment;
 - b. it is rendered in accordance with generally accepted medical practice and professionally recognized standards;
 - c. it is not treatment that is generally regarded as experimental or unproven; and
 - d. it is specifically allowed by the licensing statutes which apply to the provider who renders the service.
7. **Policy** means the Policy including all amendments, riders and endorsements.
8. **Policyholder** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.
9. **Sickness** means a dental infirmity of an Insured Individual that is the sole cause of loss.
10. **Reasonable and Customary** means, with regard to charges for dental services or supplies, the lowest of:
 - a. the usual charge by the provider for the same or similar dental services or supplies;
 - b. the usual charges of most providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies; or
 - c. the actual charge for the services or supplies.

"Area" means the location where the dental care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of dental care or supplies.

OPTIONAL STUDENT ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

IMPORTANT NOTICE: The ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) benefits only apply to Policy BLK-4554-[XXX] [(Reissued)], if it is so specified in the POLICY SCHEDULE or otherwise added by Amendment.

SCHEDULE

Student Only Coverage

[Maximum Amount of Insurance [\$5,000]]
[Maximum Amount of Insurance An amount in increments of \$5,000 equal to the amount selected by the Policyholder/Educational Facility for all of its Insured Students, not to exceed \$50,000.]

[Reduction Schedule]

[The benefit amount at age 65 or over will be reduced to [50%] of the otherwise applicable amount.]

[Coverage terminates at age 70.]

* * * * *

Benefit: means the amount the Company will pay for covered losses.

The Company will pay the applicable amount of AD&D Benefit if the Insured Student suffers the loss of life, limb or sight as the direct result of an Injury while covered for this Benefit. But the Company will only pay the Benefit after the Company receives written proof of such loss at its home office. The loss must be incurred within [90 days] of the accident.

[The Company will pay the following for the [accidental loss of] [total use of] :

| | |
|---|----------------------------------|
| [Life | The maximum amount] |
| [A hand by severance through or above the wrist | One-half the maximum amount] |
| [A foot by severance through or above the ankle | One-half the maximum amount] |
| [Irrecoverable loss of sight of one eye | One-half the maximum amount] |
| [Speech or hearing | One-half the maximum amount] |
| [Quadriplegia*] | [The maximum amount] |
| [Paraplegia or Hemiplegia*] | [One-half the maximum amount] |
| [Thumb and index finger of same hand] | [One-quarter the maximum amount] |

[* **“Quadriplegia”** means total Paralysis of both upper and lower limbs; **“Paraplegia”** means both lower limbs; **“Hemiplegia”** means total Paralysis of upper and lower limbs on one side of the body. **“Paralysis”** means loss of use, without severance, of a limb. This loss must be determined by a Doctor to be complete and not reversible.]

| | |
|--|-------------------------------|
| [Both hands or both feet | The maximum amount] |
| [Sight of both eyes | The maximum amount] |
| [Combination of two: hand, foot or sight | The maximum amount] |
| [Speech and hearing | The maximum amount] |
| [One hand, one foot or sight of one eye | One-half the maximum amount] |
| [Two or more Members**] | [The maximum amount] |
| [Irrecoverable loss of speech and hearing (both ears)] | [The maximum amount] |
| [One Member**] | [One-half the maximum amount] |
| [Irrecoverable loss of speech or hearing (both ears)] | [One-half the maximum amount] |

[** “**Member**” means hand, foot or eye.]

[The Company will not pay more than the maximum Benefit amount for all losses the Insured Student suffers as a result of one accident. Payment will be made to the Insured Student. Benefits for accidental loss of life will be paid as shown under the Beneficiary provision.]

[ONE amount, the largest, will be paid for all Injuries resulting from one accident.]

EXCEPTIONS AND EXCLUSIONS

The Company will not pay any AD&D Benefit for loss connected in any way with:

- [1.] [Bodily or mental conditions that existed at the time of or prior to the accident.]
- [2.] [Intentionally self-inflicted Injury; suicide, or attempted suicide, while sane or insane; or Injury resulting from taking part in the commission of an assault or felony.]
- [3.] [Ptomaine or bacterial infection other than a pyogenic infection that results from an accidental bodily Injury, or a bacterial infection that results from the accidental ingestion of contaminated substances.]
- [4.] [Act of war (declared or undeclared), insurrection, terrorism, participation in the military service of any country, or participation in a riot or civil disorder.]
- [5.] [Aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly schedule commercial airline.]
- [6.] [Accidental bodily Injury if it arises out of employment for pay, profit or gain.]
- [7.] [Operating any vehicle, if at that time the Insured Student had a blood alcohol level greater than the legal limit as determined by the laws and/or decision of the jurisdiction in which the loss occurred.]
- [8.] [Loss suffered in the Student’s home country or country of regular domicile.]
- [9.] [Loss suffered while the Insured Student is ineligible for this coverage.]

BENEFICIARY

“**Beneficiary**” means the person(s) who will receive the Insured Student’s accidental loss of life benefit. Unless the Insured Student indicates otherwise, the Company will pay the Benefit in this order to:

1. the Insured Student’s spouse, if living;
2. the Insured Student’s Children, in equal shares;
3. the Insured Student’s parents, in equal shares, or to the survivor;
4. the Insured Student’s estate (if no Beneficiary survives the Insured Student).

The Insured Student can name or change the Beneficiary at any time by sending written notice to the Company’s home office on a form the Company approves. If the Insured Student names more than one Beneficiary, the Company will pay the Benefit in equal shares unless the Insured Student indicates otherwise.

If the Company pays the Benefit before receiving the notice of a change in Beneficiary, the Company does not have to pay the Benefit again. If the Insured Student’s Beneficiary dies before the Insured Student does, the Company will pay the Benefit to any remaining Beneficiaries.

[When this plan replaces a Group Policy the Company previously issued (and under which the Insured Student was previously covered) the Insured Student’s named Beneficiary and his/her elected settlement option will remain the same unless changed by the Insured Student as shown above.]

DEFINITIONS - Accidental Death and Dismemberment

Unless separately defined herein, wherever used in Accidental Death and Dismemberment section of the Policy:

1. **Injury** means an accidental bodily injury sustained by an Insured Student which results directly from an accident which occurs independent of any and all other causes.
2. **Insured Student** means an individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
3. **Physician or Doctor** means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.
4. **Policy** means the Policy including all amendments, riders and endorsements.
5. **Policyholder** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.

CLAIM PROVISIONS

Notice and Proof of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Company (or its authorized representative) within 60 days after the event, or as soon thereafter as is reasonably possible. When the Company receives the notice of claim, it will send the claimant forms for filing proof of claim. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of claim requirements by giving the Company a statement in writing of the nature and extent of the loss within the time required.

Written proof of loss must be furnished to the Company within 90 days after the date of loss. However, in case of claims for loss for which the Policy provides any payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the company is liable. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss. If it was not reasonably possible to give notice and proof in writing in the time required, the Company shall not reduce or deny the claim for this reason if proof is filed as soon as reasonably possible.

Payment of Claim: Benefits will be paid as soon as the Company receives satisfactory proof of loss. All benefits [(other than for accidental loss of life)] will be paid to the Insured Student subject to any written assignment of benefits by the Student which is authorized by the Policy and made on a form satisfactory to the Company.

[If an Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.]

If the Insured Student dies without making a written assignment of benefits, the Company will pay benefits to the Insured Student's estate. The Company may, at its option, pay all or part of the benefits to a provider or person who treats or cares for the Insured Individual. Such payment made in good faith will discharge the Company to the extent of the amount paid.

Physical Examinations and Autopsy: The Company, at its own expense, has the right to examine the person with respect to whom benefits are claimed as often as reasonably needed while the claim is pending. It may also have an autopsy made unless against the law.

Legal Actions: No action at law or in equity may be brought to recover on the Policy before the end of 60 days and after proof in writing of the loss has been given, as required by the Policy. No such action may be brought after 3 years from the time written proof of loss is required to be given or after such shorter period of years allowed by law in the applicable jurisdiction.

Assignments and Claims of Creditors: The Insured Student may assign the Major Medical Benefits (and Dental Care Benefits, if any) under the Policy only to such person or institution rendering services or furnishing supplies for which benefits are payable. The Company shall not be responsible for the validity of any such assignment. Any payment made according to such assignment and in good faith by the Company will discharge the Company to the extent of any such payment.

[If an Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.]

To the extent permitted by law, neither the benefits nor payments under the Policy will be subject to the claim of creditors or to any legal process by any creditor of the Insured Individual or beneficiary.

Right of Reimbursement: The Company shall have a lien against any recovery received by an Insured Individual as compensation for an Injury or Bodily Infirmary to the extent that the Insured Individual received benefits for such Injury or Bodily Infirmary under the coverage of the Policy. The Company's lien will apply to such recovery made by the Insured Individual from any person, or entity that was responsible for causing such Injury or Bodily Infirmary or their insurers. The Insured Individual will not be required to return to the Company more than the amount which was recovered for such Injury or Bodily Infirmary.

The Insured Individual (or a parent or a guardian if the Insured Individual is not able to execute such papers) will execute and deliver such papers as may be required by the Company. Also, the Insured Individual will do whatever else is needed to help the Company in its attempts to recover the benefits it paid under the Policy to the Insured Individual or the individual's assignee.

GENERAL POLICY PROVISIONS

Entire Contract: [The entire contract is made up of this Policy, with the attached copy of the Policyholder's application and other attached papers, if any; and the attached individual applications, if any.] [The entire contract is made up of this Policy, with the attached copy of the Policyholder's application for Policy [BLK-4554-XXX], the amendment in acceptance of enhanced benefits under Policy [BLK-4554-XXX (Reissued)] and other attached papers, if any; and the attached individual applications, if any.]

All statements made by the Policyholder or by an Insured Individual shall be deemed representations and not warranties. Misstatements shall not be used in any context or to reduce claims under this Policy, unless it is in writing. A copy of the application containing such misstatement must have been given to the Policyholder, the Insured Individual or to his beneficiary, if any.

Misstatement of Age: If the age of an Insured Individual has been misstated, any amounts payable will be the ones the premium would have purchased at the correct age. Any such misstatement shall neither continue insurance ended by valid means nor void insurance otherwise valid and in force.

Sex and Number: When used in the Policy, the masculine includes the feminine; the singular, the plural; and the plural, the singular.

Clerical Error: Clerical error by the Policyholder or the Company shall not make the coverage of an ineligible person valid nor continue coverage that was ended by valid means. Neither the passage of time nor the payment of premiums for a person who is not eligible for coverage under the terms of this Policy will make this coverage valid for such person. If it is found that such a person was included when the premium was figured for this Policy, the only liability of the Company shall be the proper refund of premiums. In addition, when a person is no longer eligible for coverage under this Policy, the payment of premiums for such person shall not continue coverage past the date such person ceases to be eligible. Again, the only liability of the Company shall be the proper refund of premiums.

Authority: No agent has the right to change the Policy or to waive any part of it. Waiver of any provision of the Policy by the Company shall not effect its right to enforce the provision at any time thereafter against any person or entity claiming rights under the Policy.

Policy Changes: The Policy may be amended at any time by the Company without the consent of any person or entity claiming rights under the Policy and without notice to any Insured Individual or any person or entity claiming rights through them or on their behalf. However, the Company will provide at least 30 days advance written notice to the Policyholder of any amendments to the Policy.

Termination of This Policy: The Policyholder may cancel this Policy by giving notice, in writing, to the Company at its home office. This Policy will be in effect until the later of:

1. the date the Company receives such notice; or
2. the date set by such notice;

subject to the Policy ending prior to this notice because of the Grace Period.

If premiums are not paid, this Policy shall end as stated in the Grace Period.

[The Company may refuse to renew or continue in force the health care coverage under this Policy by giving notice, in writing to the Policyholder, at least 31 days prior to the date it is to be canceled:

1. for fraud or intentional misrepresentation of material fact by the Policyholder; [or]
2. if the Company's minimum participation requirements cannot be met[;][.] [or]
- [3. with respect to a Provider network, if there is no longer any Insured Individual who lives or attends school in the service area].]

[The Company may end Accidental Death and Dismemberment coverage, if any, by giving notice in writing to the Policyholder at least 31 days prior to the date it is to be canceled.]

The Company may terminate this policy by giving notice, in writing, to the Policyholder at least 31 days prior to the date insurance will end if the following minimum participation requirements are not met:

1. the number of Insured Students is less than [10] during any school term other than the summer term; or
2. if less than 100% of those Eligible Students who do not already have medical or health care coverage from other sources are insured under this Policy.

[If the Company discontinues a particular type of health coverage, the Company will provide notice to the Policyholder at least 90 days prior to the discontinuance of such type of coverage. The Policyholder will be given the option to purchase other health coverage currently being offered in the same market. The Policyholder will be responsible for distribution of the notices to those covered under the Policy. The Company will comply with any required state notices.

If the Company elects to discontinue all group health coverage in a market, the Company will provide notice to the Policyholder and to the [state] Insurance Department at least 180 days prior to the nonrenewal or the discontinuance of such health coverage. The Policyholder will be responsible for distribution of the notice to those covered under the Policy.

The Company may end the health care coverage only for reasons stated in the Policy or with the express consent of the [state] Insurance Department.]

Cancellation of the Policy or any of its provisions may be without the consent of the Policyholder or any person claiming rights or benefits under this Policy. If this Policy cancels, it shall not affect any claim that begins before the date this Policy or such provision ends, subject to the terms and conditions of this Policy.

The Company shall refund the pro rata portion of any premium paid for a period of time beyond the date on which the Policy ends.