

SERFF Tracking Number: INCS-125874010 State: Arkansas  
Filing Company: Pan-American Life Insurance Company State Tracking Number: 40702  
Company Tracking Number: PALIC STUDENT ACCIDENT  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student  
Product Name: PALIC Student Accident  
Project Name/Number: /STAH-GL-P

## Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: PALIC Student Accident SERFF Tr Num: INCS-125874010 State: ArkansasLH  
TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed State Tr Num: 40702  
Sub-TOI: H04.001 Student Co Tr Num: PALIC STUDENT State Status: Approved-Closed  
ACCIDENT  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Renee Weaver Disposition Date: 11/04/2008  
Date Submitted: 10/27/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:  
Project Number: STAH-GL-P  
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: Domicile state does not require prior approval.

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 11/04/2008  
State Status Changed: 11/04/2008  
Corresponding Filing Tracking Number:

Market Type: Group  
Group Market Size: Small and Large  
Group Market Type: Blanket

Filing Description:

Deemer Date:

Submission for:

Pan-American Insurance Company

NAIC#: 67539

FEIN#: 72-0281240

SERFF Tracking Number: INCS-125874010 State: Arkansas  
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RE: Group Blanket Accident and Sickness Policy

Forms:

Policy: STAH-GL-P

Amendment STAH-GL-R

Group Application: STAH-GL-APP

Innovative Compliance Solutions has been retained by Pan American Life Insurance Company to file the above mentioned filing in your state. Please address any future correspondence and/or approvals to my attention.

Enclosed for your consideration is Pan-American Life Insurance Company's Group Blanket Accident and Sickness Insurance Product. These forms are new and will not replace any forms that have been previously approved in your state.

This product provides blanket accident and sickness insurance to eligible students and their dependents. The policy will be issue directly to the Policyholder. The Policyholder will apply for coverage via the Master Application.

To provide flexibility, all variable text is indicated by brackets. The bracketed text shows the most restrictive provision that would be offered to the insured. Generally, any provision in brackets may be included in the certificates issued or may be removed in accordance with the plan options offered to groups and the election made by the groups applying. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary. Variable text will never exclude or limit provisions required by the jurisdiction in which the Group Policy is issued.

Please note the following information:

1. The company's state of domicile is Louisiana and does not require prior filing or approval.
2. Sale of the product will be through properly licensed agents and brokers.
3. The Policy Amendment/Amendatory Rider will be used to make changes to a Policy after its effective date. Only the bracketed text areas would be changed as described above.
4. Forms are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less that that required by your state. We would like to reserve the option of using the form in its submitted format electronically.

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To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Should you have any questions, or need additional information, please contact me by email at [rweaver@innovative-compliance.com](mailto:rweaver@innovative-compliance.com) or by telephone at 763-323-8643. My fax number is 763-712-8001.

Sincerely,

Renee Weaver  
Compliance Consultant

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - innovativecompliancesolutions)

Renee Weaver, Consultant [rweaver@innovative-compliance.com](mailto:rweaver@innovative-compliance.com)  
PO Box 773 (763) 323-8643 [Phone]  
Anoka, MN 55303 (763) 712-8001[FAX]

### Filing Company Information

Pan-American Life Insurance Company CoCode: 67539 State of Domicile: Louisiana  
601 Poydras St Group Code: Company Type:  
New Orleans, LA 70130 Group Name: State ID Number:  
(877) 569-3075 ext. [Phone] FEIN Number: 72-0281240  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation: \$100 per filing  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	\$100.00	10/27/2008	23501373

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/04/2008	11/04/2008

### 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	10/28/2008	10/28/2008	Renee Weaver	11/03/2008	11/03/2008

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
POLICY AMENDMENT	Form	Renee Weaver	10/28/2008	10/28/2008

SERFF Tracking Number: INCS-125874010 State: Arkansas  
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## Disposition

Disposition Date: 11/04/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Authorization Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Filing Fee Form	Approved-Closed	Yes
<b>Form (revised)</b>	POLICY	Approved-Closed	Yes
<b>Form</b>	POLICY	Replaced	Yes
<b>Form (revised)</b>	POLICY AMENDMENT	Approved-Closed	Yes
<b>Form</b>	POLICY AMENDMENT	Replaced	Yes
<b>Form</b>	APPLICATION	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/28/2008

Submitted Date 10/28/2008

Respond By Date

Dear Renee Weaver,

This will acknowledge receipt of the captioned filing.

### Objection 1

- POLICY (Form)

Comment: The benefits payable to a PPO and Non-PPO is not in compliance with our Bulletin 9-85, 2, which states in part that the difference in benefits levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

### Objection 2

- POLICY (Form)

Comment: Coverage for a newborn infant must be for at least 90 days as outlined under ACA 23-79-129. Also, please refer to the 60-day period for minors for whom the insured has filed a petition to adopt under ACA 23-79-137.

### Objection 3

- POLICY (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-131(b) and Bulletin 14-81.

### Objection 4

- POLICY (Form)

Comment: The "more than three year period" for reconstruction surgery for mastectomies does not seem to comply with ACA 23-99-405 (2).

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 11/03/2008  
 Submitted Date 11/03/2008

Dear Rosalind Minor,

### Comments:

### Response 1

Comments: The paragraph referencing 'more than three year period' has been removed.

I trust that these revisions will allow the Department to complete its review of this filing. If you have any questions or comments, please contact me.

Thank you.

### Related Objection 1

Applies To:

- POLICY (Form)

Comment:

The "more than three year period" for reconstruction surgery for mastectomies does not seem to comply with ACA 23-99-405 (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
POLICY	STAH-GL-P-AR		Policy/Contract/Fraternal Certificate	Initial		45	AR Pan American Life Ins Co-

*SERFF Tracking Number:* INCS-125874010      *State:* Arkansas  
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*Product Name:* PALIC Student Accident  
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Blanket  
Accident &  
Sickness  
Policy 10-  
30-08.pdf

**Previous Version**

<i>POLICY</i>	STAH-GL- P-AR	<i>Policy/Contract/Fraternal Initial Certificate</i>	45	AR Pan American Life Ins Co- Blanket Accident & Sickness Policy.pdf
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Project Name/Number: /STAH-GL-P

No Rate/Rule Schedule items changed.

## Response 2

Comments: The range for non PPO benefits has been changed so that the difference between PPO and non PPO benefits does not exceed 25% in benefit level.

### Related Objection 1

Applies To:

- POLICY (Form)

Comment:

The benefits payable to a PPO and Non-PPO is not in compliance with our Bulletin 9-85, 2, which states in part that the difference in benefits levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 3

Comments: The definition of Dependent has been revised for newborns and children pending adoption, as requested.

### Related Objection 1

Applies To:

- POLICY (Form)

Comment:

Coverage for a newborn infant must be for at least 90 days as outlined under ACA 23-79-129. Also, please refer to the 60-day period for minors for whom the insured has filed a petition to adopt under ACA 23-79-137.

### Changed Items:

No Supporting Documents changed.

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No Form Schedule items changed.

No Rate/Rule Schedule items changed.

#### **Response 4**

Comments: The handicapped paragraph of the Dependent definition has been revised by removing the time limit to submit proof.

#### **Related Objection 1**

Applies To:

- POLICY (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-131(b) and Bulletin 14-81.

#### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Renee Weaver

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**Amendment Letter**

Amendment Date:  
 Submitted Date: 10/28/2008

**Comments:**

The wrong form was attached for the Policy Amendment. The new form has been added. I apologize for the inconvenience.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
STAH-GL-R	Policy/Contract/Fraternal Certificate: T Amendment, Insert Page, Endorsement or Rider	POLICY AMENDMENT	Initial				45	Generic PALIC-Blanket Accident & Sickness Rider-Final Approved Version.pdf

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## Form Schedule

Lead Form Number: STAH-GL-P

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	STAH-GL-P-AR	Policy/Contract/Fraternal Certificate	POLICY	Initial		45	AR Pan American Life Ins Co-Blanket Accident & Sickness Policy 10-30-08.pdf
Approved-Closed	STAH-GL-R	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	POLICY AMENDMENT	Initial		45	Generic PALIC-Blanket Accident & Sickness Rider-Final Approved Version.pdf
Approved-Closed	STAH-GL-A	Application/Enrollment Form	APPLICATION	Initial		0	Generic Master App STAH-GL-APP.pdf

**BLANKET STUDENT ACCIDENT & SICKNESS POLICY**



Pan-American Life Insurance Company  
(hereinafter "Company")  
[601 Poydras Street  
New Orleans, Louisiana 70130]

**POLICYHOLDER:** [xxxxxxxxxx]  
**POLICY NUMBER:** [xxxxxxxxxx]  
**POLICY EFFECTIVE DATE:** [Date]  
**POLICY TERM:** [Date through Date]  
**STATE OF DELIVERY:** [State]

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:00 A.M., on the last day of the Policy Term unless the Policyholder and We agree to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the Premium Due Date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the state in which it is delivered.

Signed for PAN-AMERICAN LIFE INSURANCE COMPANY at New Orleans, Louisiana

A handwritten signature in black ink, appearing to read "David S. Sargent".

President and Chief Executive Officer

**[NOTICE REGARDING GUARANTEED AVAILABILITY OF BASIC AND STANDARD PLANS FOR BENEFITS TO ELIGIBLE PERSONS:** As described under the Health Insurance Portability And Accountability Act of 1996, eligible persons with health problems may find it more advantageous to choose a basic or standard plan of benefits from an insured that offers such plans in lieu of this blanket student accident and sickness policy. ]

**THIS IS A LEGAL CONTRACT  
PLEASE READ THE POLICY CAREFULLY  
NON-PARTICIPATING**

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ELIGIBILITY FOR INSURANCE	X
EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL	X
EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE	X
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TERMINATION DATE OF INSURANCE	X
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[RENEWABILITY OF COVERAGE	X]
PREEXISTING CONDITIONS	X
MANAGED CARE PROVISIONS	X
DESCRIPTION OF BENEFITS	X
COORDINATION OF BENEFITS	X
EXCLUSIONS	X
GENERAL PROVISIONS	X]

## SCHEDULE OF ELIGIBLE CLASSES

A person may be insured under only one eligible class as set forth herein though he or she may be eligible under more than one class. Also, a person may not be insured as a Dependent and an Insured at the same time.

**[Class 1:** All full-time [and part-time] Domestic Students enrolled in and engaged in educational activities at Policyholder who cannot provide proof of an equal or better insurance plan will automatically be billed for coverage in the student health insurance plan.

**Class 2:** All full-time [and part-time] International Students or other persons possessing and maintaining a current passport and valid visa status (F-1, J-1 or M-1 etc.) engaged in educational activities at Policyholder who are temporarily located outside their Home Country and have not been granted permanent residency status are required to be insured under this Policy.

**Class 3:** All full-time [and part-time] Domestic [and International Students] enrolled in Policyholder while traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

**Class 4:** Dependents of Insureds as defined in the Definition Section of this Policy.]

[To be a Covered Person under this Policy, the person must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the Policyholder to Us. All Insureds must actively attend classes for the first 45 consecutive days following their effective date for the term purchased and/or pursuant to their visa requirements for the period for which coverage is purchased except in the case of medical withdrawal or during school authorized breaks. ]

We maintain Our right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that the Policy eligibility requirements have not been met, Our only obligation is a pro-rata refund of premium.

## SCHEDULE OF BENEFITS

Unless otherwise specified, Benefit Maximums apply on a per Covered Person, per Covered Accident/Covered Sickness basis.

Total Benefit Maximum for all Covered Expenses per covered Accident/Sickness: [\$50,000, \$100,000, \$250,000, \$500,000 or \$1,000,000]

Preferred Provider Deductible: [\$50, \$100, \$250, \$500, \$1,000] per Covered Person

Out-of-Network Deductible: [\$50, \$100, \$250, \$500, \$750, \$1,000] per Covered Person

[The Deductible is waived for the following Benefits:

]

### COVERAGE

### BENEFIT AMOUNT

#### HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum:

Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum

Miscellaneous Hospital Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[55%, 65%, 75%] of Reasonable Customary

Benefit Maximum:

Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum

#### SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Inpatient Surgery Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum:

Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum

Outpatient Surgery Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[55%, 65%, 75%] of Reasonable & Customary

Multiple Surgical Procedure Expense Covered Percentage: Paid according to Policy language

Anesthesia Expense Covered Percentage:

[10%, 20%, 25%] of the paid Surgical Expense

Assistant Surgeon Expense Covered Percentage: [10%, 20%, 25%] of the paid Surgical Expense

**IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$250, \$500, \$1,000] per day with 30 day maximum

**OUTPATIENT EXPENSE BENEFIT**

Doctor's Office Visit Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Co-payment: [\$10, \$15, \$20, \$25] for Preferred Provider;  
[\$15, \$20, \$25, \$30] for Out-of Network provider

Chiropractic Care Office Visit Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$250, \$500, \$1,000, \$2,000] per Policy Year

Emergency Room Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%, 80%] of Reasonable & Customary for a Medical Emergency and [55%, 65%, 75%] of Reasonable & Customary for all other

Co-payment: [\$25, \$35, \$45, \$50, \$75, \$100, \$150] [(waived if admitted)]

Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Co-payment: [\$15, \$20, \$25] per condition  
Benefit Maximum: [\$500, \$750, \$1,000] per condition

[Physical Therapy Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance

Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$40, \$50, \$60, \$70] per visit, one visit per day with a 10 visit maximum]

[Speech Therapy Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary]

[Acupuncture Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary]

Benefit Maximum: [\$500, \$750, \$1,000] per Policy Year]

[Shots & Injections in a Doctor's Office Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary]

**MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum [\$10,000, \$25,000] per Policy Year

Outpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$40, \$50, \$60, \$70] per visit with a [\$500, \$1000, \$1500] per condition, per Policy Year

**SERIOUS MENTAL ILLNESS EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Outpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

**ALCOHOL & DRUG ABUSE EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:

Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$5,000, \$10,000, \$15,000, \$25,000] per Policy Year

Outpatient Expense Covered Percentage:

Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$2,500, \$5,000 \$10,000] per Policy Year

Benefit maximum for the treatment for withdrawal from the psychological effects of alcohol or drugs:

[\$1,500, \$2,500, \$5,000] per Policy Year

**[MATERNITY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary ]

**MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

**RECONSTRUCTIVE BREAST SURGERY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

**CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

**[ACCIDENTAL DEATH & DISMEMBERMENT**

Principal Sum: [\$2,500, \$5,000, \$10,000, \$25,000 or \$50,000] [(Insured only)] ]

**[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT**

Covered Percentage Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$200 per tooth or \$500, \$750, \$1,000] [\$2000] per Policy year]

**[AMBULANCE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$500, \$750, \$1,000] per Policy Year]

**[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$1000, \$2,500, \$5,000] per Policy Year]

**[HOME HEALTH CARE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [50, 75, 100] visits per calendar year]

**[LICENSED NURSE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

**[HOSPICE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary ]

**[PRE-ADMISSION TESTS EXPENSE BENEFIT**

Covered Percentage: Paid under Hospital Miscellaneous]

**[PRESCRIPTION DRUG EXPENSE BENEFIT**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Co-payment: Brand Name Drugs: [\$10, \$20, \$25, \$30] per prescription  
Generic Name Drugs: [\$5, \$10, \$15, \$20] per prescription

Benefit Maximum: [\$250, \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$5,000] per Policy Year]

**[CLINICAL TRIAL OR STUDY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

**[INHERITED METABOLIC DISEASE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary

Benefit Maximum: [\$2,500, \$5,000, \$7,500] per Policy Year for Special Food Products]

**[DIABETES SELF MANAGEMENT PROGRAM EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary]

**[COLORECTAL CANCER SCREENING EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary ]

**[WELL BABY EXAMINATIONS AND CHILDHOOD IMMUIZATIONS EXPENSE BENEFIT**

Covered Percentage: Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [55%, 65%, 75%] of Reasonable & Customary ]

**[HOME COUNTRY EXTENSION BENEFIT**

Period of Coverage [30, 60 Days] ]

**[REPATRIATION OF REMAINS BENEFIT**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Benefit Maximum: [\$5,000, \$10,000, \$15,000, \$20,000, \$25,000] ]

**[EMERGENCY MEDICAL EVACUATION BENEFIT]**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Benefit Maximum: [\$10,000, \$25,000, \$50,000]]

**[INTERCOLLEGIATE SPORTS COVERAGE**

Maximum per Injury: [\$1,500 ]  
Maximum per Tooth: [\$150] ]

**[SCHEDULE OF PREMIUM RATES**

	[From Date to Date]
[Student	[\$0000.00]
Spouse	[\$0000.00]
Child(ren)	[\$0000.00]]

Premiums received by Us are fully earned upon receipt. In addition to the eligibility requirement specified in the Eligibility for Insurance provision, refund of premiums will be considered only: 1) for Insureds withdrawing from a Study Abroad Program entirely before the departure date; or 2) for a Covered Person entering the Armed Forces of any country. Such person will not be covered under the Policy as of the date of his or her entry into to Armed Forces. A refund of unused premium will be made for such person with 90 days of withdrawal from the Policyholder when written notice is received by Us. No other refunds will be made. ]

## DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**“Accident”** means a sudden, unexpected and unintended event.

**“Covered Accident”** means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

**“Coinsurance”** means the percentage of Reasonable and Customary Charges for which the Covered Person is responsible for a covered service.

**“Complications of Pregnancy”** means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion).

**“Co-payment”** means the specified dollar amount a Covered Person must pay for specific charges. The co-payment is separate from and not a part of the Deductible or Coinsurance.

**“Covered Allowance”** means that part of the Covered Expenses that is payable by the Company after the Deductible or Co-payment has been met.

**“Covered Expenses”** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply was rendered or obtained.

**“Covered Loss” or “Covered Losses”** means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy.

**“Covered Percentage”** means that part of the Covered Expenses that is payable by the Company after the Deductible or Co-payment has been met.

**“Covered Person”** means any Insured [and Dependent] who enrolls for coverage and for whom the required premium is paid.

**“Deductible”** means the amount of Covered Expenses for Covered Expenses and supplies which must be incurred by the Covered Person before specified benefits become payable.

**["Dependent"]** means (a) the Insured's spouse residing with the Insured; [the Insured's Domestic Partner;] or (b) the Insured's unmarried children under the age of nineteen (19) years [or through the age of 25 if they are full-time students at an accredited school]. Children must be fully supported by the Insured. Coverage for newborn children will consist of coverage for Sickness or Accident including necessary care or treatment of congenital defects, birth abnormalities, premature birth and routine nursery care. Such coverage will start from the moment of birth if the Insured is already insured for dependent coverage when the child is born. If the Insured does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth or any minor child placed with an Insured for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured for adoption. To continue the newborn child's dependent benefits past the first 90 days, the Insured must notify Us in writing within 90 days of the child's birth. **Coverage for a child whom a petition for adoption has been filed, will become effective the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if coverage is applied for within the 60 days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption.**

The term "children" includes an Insured's biological children, step-children, adopted children from the date of placement in the Insured's home and who depend on the Insured for their full support.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of a physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured for support and maintenance.

**The Insured must send proof of the child's dependency or handicap after the child reaches the age limit.** We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age. ]

**"Doctor"** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a Covered Person's Immediate Family Member or household.

**["Domestic Partner"]** means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Covered Person has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

**["Domestic Partnership"]** means a relationship between the Covered Person and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

- (a) [They share the same permanent residence and the common necessities of life;
- (b) They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- (c) Each is at least 18 years of age;
- (d) Each is mentally competent to consent to contract;
- (e) Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
- (f) They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - (1) have a single dedicated relationship of at least 6 months duration;
  - (2) joint ownership of residence;
  - (3) at least two of the following:
    - (i) joint ownership of an automobile;
    - (ii) joint checking, bank or investment account;

- (iii) joint credit account;
  - (iv) lease for a residence identifying both partners as tenants;
  - (v) a will and/or life insurance policies which designates the other as primary beneficiary.
- (g) The Covered Person and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

**“Domestic Student”** is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

**“Effective Date”** means the first date a student becomes covered under the Policy.

**“Elective Treatment”** means medical treatment which is not necessitated by a pathological change in the function or structure of any part of the body occurring after a Covered Person’s coverage goes into effect.

Elective Treatment includes, but is not limited to: tubal ligation, vasectomy, breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine examinations.

**“Experimental or Investigational Care”** means a service or supply:

- (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
- (b) which requires approval by any government authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

**“Home Country”** means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country which the Covered Person has declared to Us in writing as his or her Home Country.

**“Hospital”** means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place solely for the aged.

**“Hospital Confined”** means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

**“Immediate Family Member”** means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son- or daughter-in-law; and brother- or sister-in-law.

**“International Student”** is a student classified as a Non-Immigrant. For example, students holding visa types: “F” (Student), “J” (Exchange Visitor), “B” (Tourist) or “A” (Diplomat).

**“Injury”** means accidental bodily harm sustained by a Covered Person from a Covered Accident that results directly and independently from all other causes. [The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. ]

**“Insured”** means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. [An Insured is not a Dependent covered under the Policy. ]

**“Medical Emergency”** means the unexpected onset of an Injury or Sickness that requires immediate or urgent medical attention to avoid death or serious permanent damage to the body, or pain sufficient to warrant immediate care. It does not include elective or routine care.

**“Medically Necessary”** means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Covered Person or provider;
- (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Doctor may prescribe, order, recommend or approve a service or supply does not, itself, make the service or supply Medically Necessary.

**“Out-of Network Providers”** have not agreed to any pre-arranged fee schedules.

**“Policy Effective Date”** means the date the Policy takes effect as indicated on the face page of this Policy.

**“Policy Termination Date”** means the date the Policy ends, as indicated on the face page of this Policy.

**“Policy Year”** means the 12 month period beginning on the Policy Effective Date.

**“Preferred Allowance”** means the amount a Preferred Provider will accept as payment in full for Covered Expenses.

**“Preferred Providers”** are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

**“Reasonable and Customary Charge”** means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

**“Sickness”** [means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness].

**“Trip”** means travel by air, land or sea from the Covered Person’s Home Country.

**“We”, “Our”, “Us”** means the insurance company underwriting this insurance.

**“You” and “Your”** mean the Policyholder.

## ELIGIBILITY FOR INSURANCE

Each person within one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any unused premium paid for that person.

In no event will a dependent be eligible if the Insured is not eligible.

### EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL

This Policy takes effect as of the Policy Effective Date as indicated on the face page of this Policy. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided herein, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on any anniversary date of the Policy Effective Date. We will give the Policyholder at least sixty (60) days prior written notice. We also reserved the right to refuse to renew this Policy.

However, in no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.

### EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE

Insurance under the Policy will become effective at 12:01 a.m. on the latest of:

1. the Policy Effective Date;
2. the beginning date of the term for which premium has been paid;
3. the day after and enrollment form (if applicable) and premium payment are received by Us, the Policyholder or the plan administrator;
4. the day after the date of postmark if the enrollment form is mailed;
5. For international students and scholars, the date the Cover Person departs his or her Home Country to travel to the country of assignment provided that the scheduled arrival in the country of assignment is no more than 48 hours later than the departure from the Home Country (except for school authorized breaks).

[Coverage for Dependents will become effective at 12:01 a.m. on the latest of:

1. the Policy Effective Date;
2. the beginning date of the term for which premium has been paid; or
3. the day after the date the required individual enrollment form and premium payment are received by Us, the Policyholder or the plan administrator when premium payment is made within 31 days of the student's enrollment in the Policyholder's insurance plan. ]

### [LATE ENROLLMENT FOR DEPENDENTS

An Insured may add his or her Dependent as a late enrollee:

1. when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester or pro-rated premium is required even if the spouse is enrolled after the term has begun;
2. when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application for coverage must be submitted within 90 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun; and

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3. when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun.

If the Insured does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage. ]

### **TERMINATION DATE OF INSURANCE**

An Insured's coverage will end on the earlier of the date:

1. the Policy terminates;
2. the Insured is no longer eligible;
3. the period ends for which premium is paid;
4. the date the Insured enters military service in which case a pro-rata refund of premium will be made to the Insured;
5. the Insured leaves the Policyholder, and cancels his or her coverage;
6. the last day the Insured is required to be on campus at the Policyholder and/or returns to his or her Home Country, except for Insureds traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

Termination of Insurance for an Insured shall be without prejudice to any claim which starts prior thereto.

[A Dependent's coverage will end on the earliest of the date:

1. the or she is no longer a Dependent;
2. the Insured's coverage ends;
3. the period ends for which premium is paid;
4. the last day the Insured is required to be on campus at the Policyholder and/or returns to his or her Home Country, except for Insureds traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder. ]

### Certificates of Creditable Coverage

We will provide written certification of coverage to the Insured which certifies the length of:

1. The period of credible coverage that the person accumulated under the plan and any coverage under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 as that act existed on July 16, 1997, relating to the continuation of coverage; and
2. Any waiting and affiliation period imposed on the Insured pursuant to that coverage.

The certification of coverage will be provided to the Insured who was insured:

1. At the time he or she ceases to be covered under the plan if he or she does not otherwise become covered under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, as that act existed on July 16, 1997, relating to the continuation of coverage;
2. If he or she becomes covered under such a provision at the time that he or she ceases to be covered by that provision; and
3. Upon request, if the request is made not later than 24 months after the date on which he or she ceased to be covered as described in paragraphs (1) and (2) above.

## EXTENSION OF BENEFITS

We will extend benefits under the Policy for [30, 60, 90] days after a Covered Person's coverage would otherwise end if on that date he or she is:

1. Hospital Confined for an Injury or Sickness covered by the Policy; and
2. under a Doctor's care.

Any Benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits.

## [RENEWABILITY OF COVERAGE

A student who is enrolled as a regular undergraduate or graduate student at the Policyholder will be provided with continuous coverage under this Policy for himself or herself and his or her Dependents each subsequent year the Policyholder renews this Policy with Us. Once an Insured has been covered under this Policy and satisfied any Pre-existing Condition Limitation exclusion period, if applicable, coverage under this Policy will be considered continuous. The student must apply for coverage and pay premiums as described in the Policy. ]

## PRE-EXISTING CONDITION

**"Pre-existing Condition"** means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the [6 -12] months immediately preceding the Effective Date of the Insured's coverage under this Policy. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

The **"Pre-existing Condition Waiting Period"** is [6 - 12] months. If an Insured receives treatment or service for a Pre-Existing Condition: (a) We will not pay benefits for such condition until the day after a [6 – 12] consecutive month period has passed from the Insured's effective date; and (b) We will pay only for Covered Expenses incurred after such [6 – 12] consecutive month period.

The Pre-existing Condition Waiting Period will be reduced by the aggregate period of credible coverage of the Insured if the Credible Coverage was continuous to a date not more than 63 days before the Effective Date of coverage.

Payment will be in accord with the provisions of this Policy. If the Insured has a lapse in coverage for more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

The Pre-existing Condition Waiting Period will not apply:

1. [To pregnancy];
2. In the case of an Insured who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage;
3. In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.
4. In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured held Creditable Coverage and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

The provisions of paragraphs (2) and (3) do not apply to an Insured after the end of the first 63-day period during all of which the Insured was not covered under any Creditable Coverage.

**“Creditable Coverage”** means health benefits or coverage provided to a person pursuant to:

1. A group health plan;
2. A health benefit plan;
3. Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395c et seq., also known as Medicare;
4. Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec. 1396s;
5. The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefit risk pool;
8. A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seq.;
9. A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
10. A health benefit plan under Sec. 5(e) of the Peace Corps Act, U.S.C. Sec. 2504(e);
11. The children’s health insurance program established pursuant to 42 U.S.C. Sec. 1397aa to 1397jj, inclusive;
12. A short-term health insurance policy; or
13. A blanket accident and health insurance policy.

## MANAGED CARE PROVISIONS

This Policy provides benefits based on the type of health care provider the Insured or his or her Dependents selects. This Policy provides access to both Preferred Providers and worldwide coverage for Out-of-Network Providers.

This Policy will pay the Covered Percentage of the Preferred Allowance for Covered Expenses if the Insured [or his or her Dependents] uses a Preferred Provider. This Policy will pay the Covered Percentage of the Reasonable and Customary Charge for Covered Expenses if an Out-of-Network Provider is used. All payments will be subject to any applicable Deductible, Co-insurance, Maximum Benefits and other provisions or limitation in this Policy. Covered Expenses are payable in accordance with the Schedule of Benefits.

Use of Preferred Providers offers better benefits for the Insured. Out-of-Network Provider services are subject to the Deductible and higher Co-insurance. Refer to the Schedule of Benefits for a complete description of coverage.

The Insured should be aware that Preferred Provider Hospitals may be staffed with Out-of-Network Providers. It is important that the Insured verify that his or her Doctors are Preferred Providers each time he or she calls for an appointment or at the time of service.

In the event a Covered Person is receiving medical treatment from a Preferred Provider and the Preferred Provider's contract is terminated during the course of medical treatment, then:

1. The Covered Person may continue to obtain medical treatment for the medical condition from the medical provider under the Preferred Provider contract if:
  - a. the Covered Person is actively undergoing a medically necessary course of treatment; and
  - b. the medical provider and the Covered Person agree that continuity of care is desirable.
2. The medical provider is entitled to receive reimbursement for the medical treatment if the medical provider agrees to:
  - a. to provide medical treatment to the Covered Person under the same terms, including, without limitation, the rates of payment, that existed before the termination of the Preferred Provider contract; and
  - b. not to seek payment from the Covered Person for any medical service provided by the medical provider that the medical provider could not have received if the medical provider were still under the Preferred Provider contract.
3. Coverage required by this section must be provided until the later of:
  - a. the 120<sup>th</sup> days after the date the Preferred Provider contract is terminated; or
  - b. if the medical condition is pregnancy, the 45<sup>th</sup> day after:
    - i. the date of delivery; or
    - ii. if the pregnancy does not end in delivery, the date of the end of the pregnancy.
4. The requirements in this section do not apply if:
  - a. The Preferred Provider contract was terminated due to the medical incompetence or professional misconduct of the medical provider; and
  - b. No new Preferred Provider contract was entered into with the medical provider.

### Deductible, Coinsurance and Co-payment Rules

**Deductible:** The Insured's Deductible applies to all Preferred Provider and Out-of-Network Provider Covered Expenses unless specified otherwise in this Policy.

**Coinsurance/Co-payments:** Some covered services are subject to Coinsurance and Co-payments. This is the amount the Insured must pay to the Doctor or Hospital for each procedure, visit or confinement each time he or she receives a covered service including prescription drugs. The Coinsurance is not applied until after the Insured has paid any applicable Deductible that may be required under this Policy. What We pay is shown in the Schedule of Benefits.

**Waiver of Co-payment:** The Emergency Room Co-payment will be waived if the Insured is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured received Medical Emergency care.

Certain medical procedures or treatments will require a prior notification request form to be received by the Company or the Company's authorized representative a minimum of 5 business days prior to the scheduled procedure date and approval must be received prior to the commencement of the proposed medical treatment. Prior notification is also required for any procedure or treatment that the Covered Person's Doctor anticipates will exceed \$1,000.

Services requiring prior authorization are:

1. All Inpatient admissions and/or treatments;
2. Any surgeries requiring general anesthesia (Outpatient or Inpatient)
3. [Accidental Dental treatment (for emergency dental repair of natural sound teeth damaged in an accident;]
4. [Purchase or rental of Durable Medical Equipment;]
5. [Home Health Care;]
6. [RSV Immunization and other medications priced in excess of \$1,000 per refill;]
7. All cancer treatments/therapies;
8. Hemodialysis and Peritoneal Dialysis for renal failure;
9. Substance Abuse treatments/therapies;
10. Any condition, including chronic conditions that do not meet the above criteria, but are expected to accumulate over \$1,000 in Covered Expenses per Policy Year.

## DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy.

### **ACCIDENT EXPENSE BENEFIT**

When, by reason of Injury, a Covered Person incurs expenses for hospital, surgical or medical treatment, services or supplies including while traveling outside their Home Country for [up to 365 days] to engage in educational or cultural activities sponsored by the Policyholder, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

[Covered Expenses must be incurred within [52 weeks] after the date of the Accident.]

What We pay is shown in the Schedule of Benefits.

### **SICKNESS EXPENSE BENEFIT**

When, by reason of Sickness, a Covered Person incurs expenses for hospital, surgical or medical treatment, services or supplies including while traveling outside their Home Country for [up to 365 days] to engage in educational or cultural activities sponsored by the Policyholder, We will pay for the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

[Covered Expenses must be incurred within [52 weeks] after the date of the Sickness. ]

What We pay is shown in the Schedule of Benefits.

### **HOSPITAL EXPENSE BENEFIT**

#### **Part A: Hospital Room and Board Expense**

When, by reason of Injury or Sickness, a Covered Person is required to be Hospital Confined, We will pay the Covered Percentage of the Hospital room and board Covered Expense for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a newborn nursery, special care or intensive care unit.

#### **Part B: Miscellaneous Hospital Expense**

“Miscellaneous Hospital Expense” includes expenses incurred for:

1. anesthesia, anesthesia supplies and services;
2. operating, delivery and treatment rooms and equipment;
3. diagnostic x-ray and laboratory tests;
4. lab studies;
5. oxygen tent;
6. blood and blood services;
7. prescribed drugs and medicines;
8. medical and surgical dressings, supplies, casts and splints;
9. radiation therapy, intravenous chemotherapy, kidney dialysis and inhalation therapy;
10. chemotherapy treatment with radioactive substances;
11. intravenous injections and solutions and their administration;
12. physical therapy; and
13. other necessary and prescribed Hospital expenses.

We will pay the Coverage Percentage of the Covered Expenses incurred by the Covered Person during the period of Hospital Confinement for a Surgical procedure performed on an outpatient basis. What We pay is shown in the Schedule of Benefits.

## **SURGICAL EXPENSE BENEFIT**

### **Part A: Surgery Expense Benefit**

When, by reason of Injury or Sickness, a Covered Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Expenses of the Surgical Expense in connection with any one Surgical Procedure. What We pay is shown in the Schedule of Benefits.

#### **Definitions:**

**“Surgical Expense”** means charges by a Doctor for:

1. a Surgical Procedure;
2. necessary preoperative treatment during a Hospital stay in connection with such procedure; and
3. usual post-operative treatment.

**“Surgical Procedure”** means:

1. a cutting procedure;
2. suturing of a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. radiotherapy;
6. electrocauterization;
7. diagnostic and therapeutic endoscopic procedures;
8. injection treatment for hemorrhoids and varicose veins;
9. an operation by means of a laser beam.

### **Part B: Multiple Surgical Procedures Expense Benefit**

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Expense of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to fifty percent (50%) of the Covered Percentage of the Covered Expense for these procedures.

### **Part C: Anesthesia Expense Benefit**

If, in connection with such operation, the Covered Person requires the services of an anesthetist, We will pay the expense incurred, but We will not pay more than the Covered Percentage of Covered Expenses. What We pay is shown in the Schedule of Benefits.

### **Part D: Assistant Surgeon Expense Benefit**

If, in connection with such operation, the Covered Person requires the services of an Assistant Surgeon, We will pay the expense incurred, but We will not pay more than the Covered Percentage of the Covered Expenses. What We pay is shown in the Schedule of Benefits.

## **IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Covered Person, We will pay the Covered Percentage of the Covered Charges incurred for such services.

The following medical services performed by a Doctor are covered on an inpatient basis:

1. one Doctor visit per day;
2. constant care and treatment while a Covered Person is confined in an intensive care unit;
3. care by two or more Doctors during one Hospital stay when the Covered Person's condition requires the skill of separate Doctors;

4. consultation by another Doctor when request by the Covered Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.

What we Pay is shown in the Schedule of Benefits.

### **OUTPATIENT EXPENSE BENEFIT**

If, by reason of Injury or Sickness, a Covered Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility or other similar facility licensed by the state, We will pay the Covered Percentage of Covered Expenses incurred as shown in the Schedule of Benefits. What We pay is shown in the Schedule of Benefits.

#### **Outpatient Services**

Covered Expenses for "**Outpatient Services**" include the following services:

1. a Doctor's office while not Hospital Confined ;
2. [chiropractic care up to the maximum shown in the Schedule of Benefits;]
3. a Hospital outpatient department or emergency room;
4. diagnostic x-ray and laboratory testing;
5. blood and blood services if provided and billed by a Hospital or other facility;
6. [physical therapy as shown in the Schedule of Benefits;]
7. radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;
8. radiological lab or other similar facility licensed by the state;
9. surgical dressings, splints, casts and other devices used to correct fractures and dislocations;
10. [speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment after corrective surgery or following an Injury or Sickness other than a mental or learning disorder. Speech therapy must be in keeping with a Doctor's written order for type, frequency and duration;]
11. [shots or injections when received in the Doctor's office;]
12. [acupuncture up to the maximum shown in the Schedule of Benefits.]

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

With regard to a Doctor's office visit for gynecological or obstetrical services, a women is not required to first receive authorization or a referral from her primary care physician.

### **MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT**

If a Covered Person requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

#### **Benefits for Inpatient Hospital Confinement**

When a Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Covered Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility, including Hospitals. What We pay is shown in the Schedule of Benefits.

#### **Benefits for Outpatient Services**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of Mental and Nervous Conditions.

The Mental and Nervous Condition must, in the professional judgment of health care providers, be treatable and the treatment must be Medically Necessary.

Outpatient Treatment and Doctor services include charges made by an outpatient treatment department of a Hospital, community mental health facility if approved by the joint commission on accreditation of healthcare organizations or charges for services rendered in a Doctor's office. Treatment may be provided by any properly licensed Doctor, psychologist, a professional clinical counselor, professional counselor, independent social worker, clinical nurse specialist with a specialty in mental health, marriage and family therapist or other provider as required by law. What We pay is shown in the Schedule of Benefits.

**Definition**

**“Mental or Nervous Condition”** means those conditions listed in the standard nomenclature of the American Psychiatric Association.

**SERIOUS MENTAL ILLNESS EXPENSE BENEFIT**

When a Covered Person requires Hospital Confinement or outpatient services for the treatment of a Serious Mental Illness, We will pay the Covered Percentage of the Covered Expenses incurred on the same basis as any other Sickness.

Benefits are available for 30 days of Inpatient hospitalization and 60 days of outpatient medical treatment per Policy Year, excluding visits for the management of medications and that 2 visits for partial or respite care, or a combination thereof, may be substituted for each 1 day of hospitalization not used by the Covered Person.

**Definitions:**

**“Serious Mental Illness”** means any of the following biologically based mental illnesses:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Bipolar disorder;
4. Major Depressive disorder;
5. Paranoia and other psychotic disorders;
6. Panic disorder;
7. Obsessive-compulsive disorder;
8. Anorexia Nervosa;
9. Bulimia Nervosa; and
10. Delusional Disorder

**ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT**

If a Covered Person requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

**Benefits for Inpatient Confinement**

When the Covered Person is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Covered Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility by the Health Division of the Department of Health and Human Services.

What We pay is shown in the Schedule of Benefits.

### **Benefits for Outpatient Services**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency.

Outpatient Treatment and Doctor services include charges for services rendered in a Doctor's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility so long as the Hospital, community mental health facility, or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Doctor or a licensed psychologist who certifies every three months that the Covered Person needs to continue such treatment.

What We pay is shown in the Schedule of Benefits.

### **Definitions**

**"Alcohol Abuse"** means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

**"Drug Abuse"** means a condition which is characterized by a pattern of pathological use of a drug with repeated attempts to control its use and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

**"Detoxification Facility"** means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

1. monitoring the amount of alcohol and other toxic agents in the body of the individual;
2. managing withdrawal symptoms; and
3. motivating the individual to participate in the appropriate addiction treatment programs for Alcohol or Drug Abuse.

### **[MATERNITY EXPENSE BENEFIT**

We will pay benefits for a Covered Person's Covered Expenses for maternity care including routine tests, screening exams and Complications of Pregnancy for Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility unless the attending Doctor in consultation with the mother makes a decision for an earlier discharge from the Hospital.

For a mother and newborn child who remain in the Hospital for a minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for one home visit scheduled within 24 hours after Hospital discharge and an additional home visit if prescribed by an attending provider.

[Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.]

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

We cover such charges the same way We treat Covered Expenses for any other Sickness.

What We pay is shown in the Schedule of Benefits.]

#### **MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for mammographic exams. The charges must be incurred while the Covered Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

1. Any Mammogram based upon a Doctor's recommendation for women under 40 years of age; and
2. One Mammogram every twelve months for a woman 40 years of age or older or more frequently upon recommendation of a Doctor;

We cover such charges the same way We treat Covered Expenses for any other Sickness. A women is not required to first receive authorization or a referral from her primary care physician.

What We pay is shown in the Schedule of Benefits.

#### **Definition**

**"Mammogram"** means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression devise, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

#### **RECONSTRUCTIVE BREAST SURGERY EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for Reconstructive Breast Surgery the same as any other Sickness for a Covered Person's reconstructive surgery incident to a covered mastectomy. Benefits shall include reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment for any physical complications for all states of mastectomy including lymphedemas in a manner determined with the Doctor and the Covered Person.

**"Reconstructive Surgery"** means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

#### **CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT**

We cover charges for Expenses incurred for an annual Cytologic Screening (Pap Smear) for women 18 years of age or older or more frequently when recommended by a Doctor, nurse practitioner or a certified nurse midwife. Such benefits will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.

We cover such charges the same way We treat Covered Expenses for any other Sickness. A women is not required to first receive authorization or a referral from her primary care physician.

What We pay is shown in the Schedule of Benefits.

#### **Definition**

**"Cytologic Screening"** means a pap test to detect cervical cancer through the simple microscope examination of cells scraped from the surface of the cervix.

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS [(Insured Only)]**

If Injury to the Covered Person results in any one of the losses shown below, We will pay the Benefit Amount shown below for that loss. [Loss must occur within [90 days] of the date of the accident which caused the loss.] The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Accident.

Covered Loss	Benefit Amount
Life .....	100% of the Principal Sum
Two or more Members.....	100% of the Principal Sum
One Member.....	50% of the Principal Sum

“Member” means Loss of Hand or Foot, and Loss of Sight. “Loss of Hand or Foot” means complete Severance through or above the wrist or ankle joint. “Loss of Sight” means the total, permanent Loss of Sight of one eye. “Severance” means the complete separation and dismemberment of the part from the body.]

**[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT**

We will pay the Covered Percentage of Covered Expenses incurred as a result of an accidental dental injury. What We pay is shown in the Schedule of Benefits.]

**[AMBULANCE EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

What We pay is shown on the Schedule of Benefits.]

**[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT**

If, by reason of Injury or Sickness, a Covered Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for such Durable Medical Equipment. We pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is Our property and is to be returned to Us, at Our expense, upon completion of the Covered Person’s need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

What We pay is shown in the Schedule of Benefits.

**Definition**

“Durable Medical Equipment” means medical equipment that: 1) is prescribed by the Doctor who documents the necessity for the item including the expected duration of its use; 2) can withstand long term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision. ]

#### **[HOME HEALTH CARE EXPENSE BENEFIT**

We will cover charges for Home Health Care services furnished to a Covered Person. Such benefits must be provided by a licensed Home Health Agency. Except for a home health aid, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aid shall be considered as one home health visit.

Charges for such services are not subject to the Deductible. What We pay is shown in the Schedule of Benefits.

#### **Definitions**

**“Home Health Care”** means the continued care and treatment of a Covered Person who is under the direct care and supervision of a Doctor but only if: (a) continued hospitalization would have been required if Home Health Care were not provided; (b) the home health treatment plan is established and approved by a Doctor within 14 days after an inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Covered Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

**“Home Health Services”** Consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Policy if the Covered Person had remained in the Hospital.

**“Home Health Agency”** means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Health and Safety Code.]

#### **[HOSPICE EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for Hospice Care. What We pay is shown in the Schedule of Benefits.]

#### **LICENSED NURSE EXPENSE BENEFIT**

If by reason of Injury or Sickness, a Covered Person requires the services of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Expenses incurred. What We pay is shown in the Schedule of Benefits.

#### **[PRE-ADMISSION TESTS EXPENSE BENEFIT**

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Expenses made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to a Covered Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Covered Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Covered Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Schedule of Benefits for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provided for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Covered Person only to the extent that the Covered Person is insured under this Policy for Hospital Expense Benefits. What We pay is shown in the Schedule of Benefits.]

#### **[PRESCRIPTION DRUG EXPENSE BENEFIT**

If by reason of Injury or Sickness, a Covered Person requires drugs, We will pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for such drugs and the Medically Necessary services associated with the administration of such drugs subject to the Co-payment shown in the Schedule of Benefits.

The drugs must be prescribed by a Doctor. Coverage includes any type of drug or device for contraception and any type of hormone replacement therapy which is lawfully prescribed or ordered by a Doctor and which has been approved by the Food and Drug Administration.

We only cover drugs which are approved for the treatment of the Covered Person's Injury or Sickness by the Food and Drug Administration.

We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established referenced compendia:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopoeia Drug Information; or
4. it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

However, Covered Expenses do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Coverage for prescription drugs will not be limited or excluded if the drug:

1. had previously been approved for coverage for a Covered Person's medical condition and the Covered Person's medical provider determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved are medically appropriate for the Covered Person; and
2. is appropriately prescribed and considered safe and effective for treating the Covered Person's medical condition.
3. The provisions of 1 and 2 above do not:
  - a. apply to any drug that is prescribed for a use different from the use for which that drug has been approved for marketing by the Food and Drug Administration;
  - b. prohibit charging a Deductible, Co-payment or Coinsurance or from establishing maximum benefits covered under the Policy; or
  - c. a medical provider from prescribing another drug that is medically appropriate for the Covered Person.

What We pay is shown in the Schedule of Benefits.]

#### **[CLINICAL TRIAL OR STUDY EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person receives medical treatment as part of a clinical trial or study, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits if:

1. the medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;
2. the clinical trial or study is approved by:
  - a. an agency of the National Institutes of Health as set forth in 42 U.S.C. section 281(b);
  - b. a cooperative group;
  - c. the Food and Drug Administration as an application for a new investigational drug;
  - d. the United States Department of Veterans Affairs; or
  - e. the United States Department of Defense;
3. in case of:
  - a. a phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical studies for the treatment of cancer; or
  - b. A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a medical provider with qualified personnel having experience and training to provide the treatment in a capable manner.
4. There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;
5. There is no reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study is conducted in the Policyholder's state of domicile; and
6. The Covered Person has signed, before his participation in the clinical trial or study, a statement of consent indicating that he or she has been informed of, without limitation;
  - a. the procedure to be undertaken;
  - b. alternative methods of treatment; and
  - c. the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

Coverage for medical treatment under by this section is limited to:

1. coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the Covered Person.
2. reasonably necessary costs for health care services.
3. the initial consultation to determine if the Covered Person is eligible to participate in the clinical trial or study.
4. Health care services to monitor the Covered Person during the clinical trial or study.
5. Medical treatment provided by the sponsor of the clinical trial or study not free of charge to the Covered Person.

Coverage for medical treatment under this section does not include:

1. any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
2. coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device.
3. health care services that are specifically excluded by this Policy regardless of whether such services are provided under the clinical trial or study.
4. extraneous expenses including, without limitation, travel, housing and other expenses.
5. any expenses incurred by a person who accompanies the Covered Person during the clinical trial or study.

What We pay is shown in the Schedule of Benefits.]

**[INHERITED METABOLIC DISEASE EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for certain Inherited Metabolic Diseases. Benefits will include: 1) enteral formulas for use at home that are prescribed or ordered by a Doctor as Medically Necessary and characterized by deficient metabolism, or malabsorption originating from congenital defects or defect arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and 2) [\$2,500, \$5,000, \$7,500] per Policy Year for Special Food Products which are prescribed or ordered by a Doctor as Medically Necessary.

**Definition**

**“Inherited Metabolic Disease”** means a disease caused by an inherited abnormality of the body chemistry of a person.

**“Special Food Product”** means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the directions of a Doctor for the dietary treatment of an Inherited Metabolic Disease. The term does not include food that is naturally low in protein.]

**[DIABETES MANAGEMENT AND TREATMENT EXPENSE BENEFIT**

We cover charges for Covered Expenses relating to the management and treatment of diabetes, including, without limitation, coverage for the self-management of diabetes. Diabetes includes type I, type II and gestational diabetes.

We cover such charges the same way We treat Covered Expenses for any other Sickness. What We pay is shown in the Schedule of Benefits.

Coverage for the management and treatment of diabetes includes coverage for medication, equipment, supplies and appliances that are Medically Necessary for the treatment of diabetes.

Coverage for the self-management of diabetes includes:

1. the training and education provided to the Covered Person after he or she is initially diagnosed with diabetes which is Medically Necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
2. training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Covered Person and which requires modification of his or her diabetic self management program; and
3. training and education which is Medically Necessary because of the development of new techniques and treatment for diabetes. ]

**[COLORECTAL CANCER SCREENING**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for screening of Colonrectal Cancer.]

**[WELL BABY CARE AND IMMUNIZATION EXPENSE BENEFITS**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for Medically Necessary preventative medical services rendered to the Insured's child up to the age of 2 enrolled as a Dependent which include:

1. physical examinations;
2. immunizations;
3. history measurements;
4. sensory scanning;
5. neuropsychiatric evaluation and development;
6. screening and assessments.

The Deductible and Coinsurance requirements shown in the Schedule of Benefits are waived. What We pay is shown on the Schedule of Benefits.]

**[HOME COUNTRY EXTENSION BENEFITS**

We will pay benefits for Covered Expenses if the Covered Person obtains follow-up treatment of an Injury or Sickness while he or she is in his or her Home Country during the course of a Trip for which a benefit is otherwise payable under the Policy.

Benefits will be paid for a period of [30-60] days from the date the Covered Person returns to his or her Home Country. Home Country Extension Benefit payments are subject to the Benefit Maximums, Covered Percentage, Deductible and Co-payment shown in the Schedule of Benefits.]

**[REPATRIATION OF REMAINS BENEFIT**

We will pay Repatriation Benefits as shown in the Schedule of Benefits for preparation and return of a Covered Person's body to his or her Home Country if he or she dies due to an Injury or Sickness. Covered Expenses include, but are not limited to:

1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains by the most direct and least costly conveyance and route possible.

Benefits will not be payable unless We authorize all expenses in advance, in writing, or by an authorized electronic or telephonic means.]

**[EMERGENCY MEDICAL EVACUATION BENEFIT**

We will pay benefits for Covered Expenses as shown in the Schedule of Benefits for a Covered Person's Emergency Medical Evacuation.

Benefits are payable if the Covered Person:

1. is traveling outside his or her Home Country;
2. suffers an Injury or Sickness during the course of the Trip; and
3. requires Emergency Medical Evacuation.

Benefits will not be payable unless:

1. the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Injury or Sickness requiring the Emergency Medical Evacuation;
2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
4. do not include charges that would not have been made if there were no insurance.

**Definitions**

**“Emergency Medical Evacuation”** means:

1. the immediate transportation from the place where the Covered Person suffers an Injury or Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or
2. transportation to your Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness.

An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation.]

**[INTERCOLLEGIATE SPORTS BENEFIT**

We will pay benefits for Covered Expenses as shown in the Schedule of Benefits if a Covered Person sustains an Injury while practicing, playing or traveling to or from an intercollegiate sports event as a member of a sports team or tryout squad are covered, up to the maximum amount shown in the Schedule of Benefits for each accident. Benefits for Injury to natural teeth will be limited to a per-tooth maximum amount.]

## COORDINATION OF BENEFITS

If a Covered Person is eligible for benefits under this policy and any other plan, We will pay benefits as explained in this provision.

### Definitions

**“Plan of Health Coverage”** means an individual or group insurance plan or an individual or group contract of a health insuring corporation providing hospital, dental, surgical or medical services or any other individual or group benefit plan or third-party payer plan providing hospital, dental, surgical or medical services. These coverages include: a) individual, group or blanket insurance coverage, or any other individual or group type contract or provision; b) service plan contracts, group practice and other pre-payment group coverage; c) any coverage under labor-management trustee plans, union welfare plans, employer and employee plans; and coverage under any government program, including Medicare, and any coverage required or provided by law. A primary plan pays benefits first. A secondary plan pays a reduced amount of benefits that when added to the benefits paid by the primary plan will not be more than the Allowable Expenses.

**“Allowable Expenses”** means any necessary, reasonable and customary item of expense, a part of which is covered by at least one of the Plans covering the Covered Person. During any Policy year or benefit period, the sum of the benefits that are payable by Us and those benefits that are payable from another Plan of Health Coverage may not be more than the Allowable Expenses. During any Policy year or benefit period, We may reduce the amount We pay so that this reduced amount plus the amount payable by the other Plan of Health Coverage will not be more than the Allowable Expenses.

Allowable Expenses under the other Plan of Health Coverage include benefits that would have been payable if a claim had been made.

However, if: 1) the other Plan of Health Coverage contains a section that provides for determining its benefits after Our benefits have been determined; and 2) the order of benefit determination stated in this Policy would require Us to determine benefits before the other Plan of Health Coverage, then the benefits of such other Plan of Health Coverage will be ignored in determining the benefits We will pay.

This Policy determines its order of benefits using the first of the following rules that applies:

1. If the other Plan of Health Coverage does not have a Coordination of Benefits, that Plan of Health Coverage pays first.
2. The benefits of the Plan of Health Coverage that covers the person as an employee, member, insured or subscriber are determined before those of the Plan of Health Coverage that covers the person as a Dependent.
3. If this Policy and another Plan of Health Coverage cover the same child as a Dependent of different parents who are not divorced or separated or divorced:
  - A. the benefits of the Plan of Health Coverage of the parent whose birthday falls earlier in the year (without regard to the year of birth) are paid before the benefits of the Plan of Health Coverage of the parent whose birthday falls later in the year;
  - B. if both parents have the same birthday, the benefits of the Plan of Health Coverage that covered the parent longer pays benefits before the benefits of the Plan of Health Coverage that covered the other parent for a shorter time.

However, if the Plans of Health Coverage do not agree on the order of benefits, the rule of the other Plan of Health Coverage will determine the order of benefits.

4. If two or more Plans of Health Coverage cover a person as a Dependent child of divorced or separated parents, benefits will be determined in this order:
  - A. first, the Plan of Health Coverage of the parent with custody of the child;
  - B. then, the Plan of Health Coverage of the spouse of the parent with custody of the child; and
  - C. finally, the Plan of Health Coverage of the parent not having custody of the child.
5. If none of the above rules determines the order of benefits, the benefits of the Plan of Health Coverage that covered an employee, member, insured or subscriber longer are determined before those of the Plan of Health Coverage that covered that person for the shorter time.

To determine how this provision should apply, We may without further consent or notice release to, or obtain from, any other insurance company or organization, any necessary information. Any person claiming benefits under the Policy shall give Us the information We need to implement this provision. We will give the Covered Person notice of this exchange of claim and benefit information when the claim is filed.

Whenever payments are made by another Plan of Health Coverage that should have been paid under the Policy, We shall pay any amount require to satisfy our share of the benefits paid. Any amounts paid in this way will be considered benefits paid under the Policy. Any payment made in good faith will end our liability to the extent of the payment.

If We pay benefits for Allowable Expenses that exceed our obligation under this provision, We may recover the excess payment. We may recover these excess payments from any person, for whom benefits were paid, or to any person or organization to which benefits were paid, or from any other insurer, service plan or other organization.

## EXCLUSIONS

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary or Hospital or by Health Care Providers employed by the Policyholder;]
2. [Preventative medicines, serums, immunizations or vaccines except as specifically provided;]
3. [Care and/or treatment in skilled nursing facility except as specifically provided;]
4. [Organ transplants;]
5. [Hospice services except as specifically provided;]
6. [Pre-existing Conditions as defined in this Policy;]
7. [Nonprescription drugs or medicines;]
8. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country except as specifically provided. Upon the Covered Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Covered Person;]
9. [Sickness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate clubs sports and professional sports[ except as specifically provided];]
10. [Injury resulting from motor vehicle accident in excess of [\$5,000, \$10,000, \$15,000, \$20,000] per Accident;]
11. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Covered Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]
12. [Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planning, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;]
13. [Correction of congenital defects except as specifically provided;]
14. [Injury of Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]
15. [Expense incurred as the result of dental treatment except as provided in the Accidental Dental Expense Benefit if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;]

16. [Expense incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision, when applicable;]
17. [Injury or Sickness resulting from declared or undeclared war or any act thereof;]
18. [Charges for treatment of any Injury or Sickness due to a Covered Person's commission of or attempt to commit a felony or a crime which would be considered a felony if prosecuted;]
19. [Injury due to participation in a riot;]
20. [Charges for which a Covered Person has no legal obligation to pay in absence of this or like coverage;]
21. [For services or supplies rendered by a close relative of the Covered Person. By "**close relative**" We mean a Covered Person's spouse, children, parents, brothers and sisters;]
22. [Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat fee; subluxation; corns, calluses; bunions except open cutting operations, routine care of toenails except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet and any tarsalgia or metatarsalgia. Expenses incurred for the care and treatment of Injury, infection or disease are not excluded;]
23. [Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination and services or supplies for inducing conception;]
24. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]
25. [Treatment for obesity including any care which is primarily dieting or exercise for weight loss except for surgical treatment of morbid obesity;]
26. [Expense incurred for eye examination or prescriptions, eyeglasses, contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, lasix or other vision procedures except as required for repair caused by a covered Injury;]
27. [Well baby care including routine exams and immunizations except as specifically provided;]
28. [Routine periodical physical examination and routine chest x-rays except as specifically provided;]
29. [Expenses incurred for allergy testing and allergy treatment;]
30. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]
31. [An amount of a charge in excess of the Reasonable and Customary Charge;]
32. [Elective Treatment or elective surgery except as specifically provided;]

33. [Services not Medically Necessary;]
34. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare paying passenger in an aircraft operating by a scheduled airline maintaining regular published schedules on a regularly established route;]
35. [Treatment of mental or nervous disorder except as specifically provided;]
36. [Treatment for alcohol and substance abuse except as specifically provided;]
37. [Suicide, attempted suicide or intentionally self-inflicted injury;]
38. [Expense incurred for: tubal ligation; vasectomy; breast implants, breast reduction, sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism and learning disabilities or disorders of Attention Deficit Disorder;]
39. [Voluntary or elective abortion; pregnancy of a dependent child;]
40. [Illegal drugs;]
41. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication, legend vitamins or food supplements, smoking deterrents, immunization agents, biological sera, drugs to promote or stimulate hair growth, experimental drugs, drugs dispensed in a rest home or hospital except as provided under the Hospital Expense Benefit;]
42. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication or for any drug which the FDA has determined to be contraindicated for a particular condition;]
43. [Testing, treatment or services for any condition in the absence of Sickness or Injury except as specifically provided;]
44. [Hearing aids, including exams for fitting except as required to correct damage caused by an Injury which occurs while the patient is covered by this Policy provided they are obtained within four months of the date of the Injury;]
45. [Expense for hair replacement, wigs or wig maintenance; or]
46. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy.]

## GENERAL PROVISIONS

**PREMIUMS** The premiums for the Policy will be based on the rates currently in force, the coverage and amount of insurance in effect.

**CHANGES IN PREMIUM RATES** We may change the premium rates from time to time with at least 60 days advanced written or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. There is a misrepresentation in the information We relied on in establishing the rate.
5. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

**PAYMENT OF PREMIUM** The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

**POLICY GRACE PERIOD** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

**ENTIRE CONTRACT; CHANGES** The entire contract is made up of: (a) this Policy, including Your application; and (b) the individual applications, if any, of Covered Persons. Statements made by the Policyholder or a Covered Person, in the absence of fraud, shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person or to his/her beneficiary. The Insured, his beneficiary or assignee has the right to make a written request to the Company for a copy of the application and the Company shall, within 15 days after the receipt of a request at its home office or any authorized agent's office, deliver or mail to the person making the request a copy of the application. If a copy is not delivered or mailed, the Company is precluded from introducing the application as evidence in any action based upon or involving any statements contained therein.

No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidence by endorsement on this Policy signed by the Policyholder and Us. No agent has authority to change this Policy or to waive any of its provisions.

**CLERICAL ERROR** If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the terms and conditions of the Policy.

**NOTICE OF CLAIM** Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any Covered Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us or to any authorized agent with information sufficient to identify the Covered Person shall be deemed notice to Us.

**CLAIM FORMS** Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of loss by giving written proof of: (a) the occurrence of the Covered Loss; (b) the nature of the Covered Loss; and (c) the extent of the Covered Loss.

**PROOF OF LOSS** Written proof of loss must be given to Us or to any authorized agent within 90 days after the date of such Covered Loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

**TIME PAYMENT OF CLAIMS** Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by Us.

**PAYMENT OF CLAIMS** All benefits other than death will be paid to the Covered Person. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. We must receive the request no later than the time for filing proof of loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured.

Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's:

1. spouse;
2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); mother or father;
3. estate.

All other benefits due and not assigned will be paid to the Covered Person, if living.

Otherwise, the benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Covered Person's estate.

If a benefit due is payable to:

1. the Covered Person's estate; or
2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment.

We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith.

The Covered Person may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Insured is the beneficiary for any covered Dependent.

**APPEALS PROCEDURE** If a claim is wholly or partially denied, a written notice will be sent to the Covered Person containing the reason for the denial. The notice will include a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal along with any additional information or comments may be sent within 6 months after notice of denial. In preparing the appeal, the Covered Person, or his/her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

**PHYSICAL EXAMINATION** At Our own expense, We have the right to have a Doctor examine a Covered Person when and so often as We deem reasonably necessary while there is a claim pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

In the event the Company, for final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any Covered Person, only a Doctor or chiropractor who is certified to practice in the same field of practice may conduct the independent evaluation. The independent evaluation must include a physical examination of the Covered Person and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of the findings must be sent to the primary treating physician or chiropractor and the Covered Person within 10 working days after the evaluation. If the Covered Person disagrees with the finding of the evaluation, he must submit an appeal to the Company pursuant to the procedure for binding arbitration set forth herein within 30 days after he receives the finding of the evaluation. The procedure for binding arbitration to resolve disputes concerning independent medical examinations shall follow the rules of the American Arbitration Association.

**LEGAL ACTIONS** No one may sue Us for payment of claim: (a) less than 60 days after due proof of claim is furnished; or (b) more than three years after the date proof of claim is required by this Policy.

**RECORDS MAINTAINED** You shall maintain records of each person insured. The records shall show all data that is needed to administer this Policy.

**REPORTING REQUIREMENT** The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. any additional information required by Us.

**EXAMINATION AND AUDIT** We shall be allowed to examine and audit Your books and records which pertain to this Policy at reasonable times. We may also be allowed to do this within 3 years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

**SUBROGATION AND RECOVERY RIGHTS** If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Covered Person will do whatever is necessary to enable Us to exercise Our right and will do nothing after to prejudice it. If We are precluded from exercising Our right to subrogation, We may exercise Our right to reimbursement.

If benefits are paid under this Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have the right to recover from that person an amount equal to that amount We paid. However, We will reimburse the Covered Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

We may exercise Our right to subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relived of liability by contract or operation of law. If We are precluded from exercising Our right of subrogation, We may exercise our right to reimbursement.

We, in exercising Our right of subrogation, will not seek to recover more than We paid under the Policy. We, in exercising our right of reimbursement, will not see to recover more than the amount recovered from a responsible third party.

**EXCESS PROVISION** No benefit under this Policy is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance. However, Injury due to a motor vehicle Accident is limited to [\$5000, \$10,000, \$15000, \$20,000] per Accident.

**ASSIGNMENT** At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefit may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

**CERTIFICATES OF INSURANCE** Where required by law, a certificate of insurance will be delivered to the Policyholder for delivery to each Covered Person. The certificate will list the benefits, conditions and limits of the Policy and will state to whom benefits will be paid.

**CONFORMITY WITH STATE STATUES** Any provision of this Policy which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.



Pan-American Life Insurance Company  
(hereinafter "Company")  
601 Poydras Street  
New Orleans, Louisiana 70130

### **POLICY AMENDMENT**

This Amendatory Rider is attached to and made part of Policy Number [xxxxxxxxx] issued by Pan-American Life Insurance Company to Policyholder.

Effective [Date], the Policy as issued is amended as follows:

#### **AMENDATORY RIDER**

I. **[Section [x] – [Name of Section]** is amended by:

[New wording]

II. **Section [x] – [Name of Section]** is amended by:

[New wording]

Signed for PAN-AMERICAN LIFE INSURANCE COMPANY at New Orleans, Louisiana

A handwritten signature in black ink, appearing to read "David Siquet".

President and Chief Executive Officer



Pan-American Life Insurance Company  
(hereinafter "Company")  
[601 Poydras Street  
New Orleans, Louisiana 70130]

**GROUP APPLICATION FOR STUDENT ACCIDENT AND SICKNESS POLICY**

**Applicant/School Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip Code

**Federal I.D. #** \_\_\_\_\_

**Name and Position of Authorized Individual** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Requested Policy Effective Date:** \_\_\_\_\_  
Month Year

**Amount of Deposit Premium submitted with the Application:** [\$\_\_\_\_\_]

**Eligible Classes:**

**[Class 1:** All full-time [and part-time] Domestic Students enrolled in and engaged in educational activities at Policyholder who cannot provide proof of an equal or better insurance plan will automatically be billed for coverage in the student health insurance plan.

**Class 2:** All full-time [and part-time] International Students or other persons possessing and maintaining a current passport and valid visa status (F-1, J-1 or M-1 etc.) engaged in educational activities at Policyholder who are temporarily located outside their Home Country and have not been granted permanent residency status are required to be insured under this Policy.

**Class 3:** All full-time [and part-time] Domestic [and International Students] enrolled in Policyholder while traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

**Class 4:** Dependents of Insureds as defined in the Definition Section of this Policy.]

**Benefit Plan:** As selected by Applicant and set forth in the attached Schedule of Benefits and incorporated by reference into this Application.

<b>Premium Rates:</b>	<b>[From Date to Date]</b>
<b>[Student</b>	<b>[\$0000.00]</b>
<b>Spouse</b>	<b>[\$0000.00]</b>
<b>Child(ren)</b>	<b>[\$0000.00]</b>

I hereby represent that all the information contained in this Group Application for Student and Accident Policy is true and complete and that I have read and understand the form. I understand that the Company will rely on these statements and this information in approving this Application.

APPLICANT/SCHOOL NAME: \_\_\_\_\_

BY: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**IMPORTANT FRAUD NOTICE[S Please review the notice that applies in your state]**

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[FRAUD STATEMENT:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA:** Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.]

**[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND, AND OREGON:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF IDAHO AND TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of fraud as determined by a court of law.]

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF WASHINGTON:** Any person who knowingly presents false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

**SCHEDULE OF BENEFITS**

Unless otherwise specified, Benefit Maximums apply on a per Covered Person, per Covered Accident/Covered Sickness basis.

Total Benefit Maximum for all Covered Expenses per covered Accident/Sickness: [\$50,000, \$100,000, \$250,000, \$500,000 or \$1,000,000]

Preferred Provider Deductible: [\$50, \$100, \$250, \$500, \$1,000] per Covered Person

Out-of-Network Deductible: [\$50, \$100, \$250, \$500, \$750, \$1,000] per Covered Person

**COVERAGE**

**BENEFIT AMOUNT**

[ *Show plan design here* ]

SERFF Tracking Number: INCS-125874010 State: Arkansas  
Filing Company: Pan-American Life Insurance Company State Tracking Number: 40702  
Company Tracking Number: PALIC STUDENT ACCIDENT  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student  
Product Name: PALIC Student Accident  
Project Name/Number: /STAH-GL-P

## Rate Information

Rate data does NOT apply to filing.

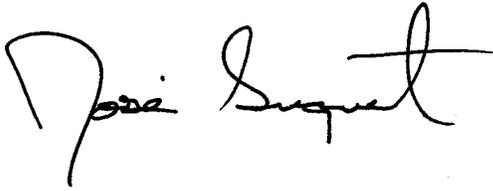
SERFF Tracking Number: INCS-125874010 State: Arkansas  
Filing Company: Pan-American Life Insurance Company State Tracking Number: 40702  
Company Tracking Number: PALIC STUDENT ACCIDENT  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student  
Product Name: PALIC Student Accident  
Project Name/Number: /STAH-GL-P

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	11/04/2008
<b>Comments:</b> The Complaint notice is shown on the Policy.		
<b>Attachments:</b> AR Certification Reg 19.pdf Readability.pdf		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	11/04/2008
<b>Bypass Reason:</b> New Application filing - under Form Schedule		
<b>Comments:</b>		
<b>Satisfied -Name:</b> Authorization Letter	<b>Review Status:</b> Approved-Closed	11/04/2008
<b>Comments:</b>		
<b>Attachment:</b> ICS Authorization 08 PALIC.pdf		
<b>Satisfied -Name:</b> Filing Fee Form	<b>Review Status:</b> Approved-Closed	11/04/2008
<b>Comments:</b>		
<b>Attachment:</b> AR Fee Schedule.pdf		

**ARKANSAS  
CERTIFICATE OF COMPLIANCE**

PanAmerican Life Insurance Company hereby certifies that the policy forms listed below are in compliance with all of the requirements of Arkansas Insurance Department Rule and Regulation 19. The benefits/coverage provided by the forms listed below are available to, and will be administered, in a non-discriminatory manner.



\_\_\_\_\_  
(Signature)

President and Chief Executive Officer

(Title)

10/23/08

(Date)

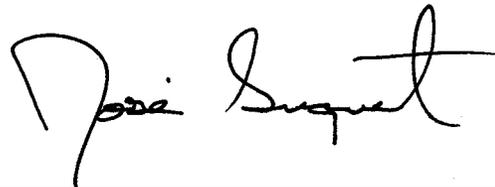
**Policy Form Numbers:**

STAH-GL-P; STAH-GL-R; STAH-GL-APP

**CERTIFICATION OF COMPLIANCE  
FOR READABILITY**

<u>Form Number(s)</u>	<u>Flesch Readability Score</u>
STAH-GL-P	45
STAH-GL-A	45

I hereby certify on behalf of Pan-American Life Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores.



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President and Chief Executive Officer

Dated: October 26, 2008

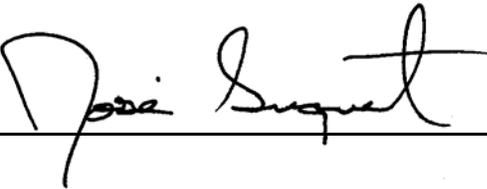
Authorization Letter

January 2008

COMPANY: Pan-American Life Insurance Company  
NAIC Number: 67539  
FEIN Number: 720281240

Please accept this letter as authorization for Innovative Compliance Solutions to act as our agent for submission of policy forms and rate information and to perform each and every act necessary in connection with such submission on behalf of Pan-American Life Insurance Company.

BY:



A handwritten signature in black ink, appearing to read "Jose Siquet", is written over a solid horizontal line.

TITLE:

President and Chief Executive Officer

Pan-American Life Insurance Company



ARKANSAS INSURANCE DEPARTMENT

1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: PanAmerican Life Insurance Company
Company NAIC Code: 67539
Company Contact Person & Telephone # Renee Weaver 763-323-8643
Form Number(s):

\*\*\*\*\*
\* INSURANCE DEPARTMENT USE ONLY \*
\* ANALYST: AMOUNT: ROUTE SLIP: \*

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Table with 2 columns: Description of filing type and Fee calculation. Includes rows for Life and/or Disability policy form filing, Life and/or Disability - Filing and review of each rate filing, Life and/or Disability Policy, Contract or Annuity Forms, Policy and contract forms, and Life and/or Disability: Filing and review of Insurer's advertisements.

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to  
amend an Insurer's Certificate of Authority.

\*0 x \$400 = 0

Filing to amend Certificate of Authority.

\*\*\*0 x \$100 = 0

\*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE  
AND REGULATION 57.

\*\*THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK.  
CODE ANN. 23-63-102, RETALIATORY TAX.

\*\*\*THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.

SERFF Tracking Number: INCS-125874010 State: Arkansas  
 Filing Company: Pan-American Life Insurance Company State Tracking Number: 40702  
 Company Tracking Number: PALIC STUDENT ACCIDENT  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student  
 Product Name: PALIC Student Accident  
 Project Name/Number: /STAH-GL-P

## 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	POLICY	10/27/2008	AR Pan American Life Ins Co-Blanket Accident & Sickness Policy.pdf
No original date	Form	POLICY AMENDMENT	10/27/2008	IA Pan American Life Ins Co-Blanket Accident & Sickness Policy.pdf

**BLANKET STUDENT ACCIDENT & SICKNESS POLICY**



Pan-American Life Insurance Company  
(hereinafter "Company")  
[601 Poydras Street  
New Orleans, Louisiana 70130]

**POLICYHOLDER** [xxxxxxxxxx]  
**POLICY NUMBER:** [xxxxxxxxxx]  
**POLICY EFFECTIVE DATE:** [Date]  
**POLICY TERM:** [Date through Date]  
**STATE OF DELIVERY:** [State]

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:00 A.M., on the last day of the Policy Term unless the Policyholder and We agree to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the Premium Due Date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the state in which it is delivered.

Signed for PAN-AMERICAN LIFE INSURANCE COMPANY at New Orleans, Louisiana

President and Chief Executive Officer

**[NOTICE REGARDING GUARANTEED AVAILABILITY OF BASIC AND STANDARD PLANS FOR BENEFITS TO ELIGIBLE PERSONS:** As described under the Health Insurance Portability And Accountability Act of 1996, eligible persons with health problems may find it more advantageous to choose a basic or standard plan of benefits from an insured that offers such plans in lieu of this blanket student accident and sickness policy. ]

**THIS IS A LEGAL CONTRACT  
PLEASE READ THE POLICY CAREFULLY  
NON-PARTICIPATING**

**Policyholder Service Office of Company:** PanAmerican Life Insurance Company  
**Address:** [601 Poydras Street, New Orleans, Louisiana 70130]  
**Telephone Number:** [1-800-xxx-xxxx]  
If we at Pan-American Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:  
**Arkansas Insurance Department - Consumer Services Division**  
**1200 West Third Street**  
**Little Rock, Arkansas 72201-1904**  
**Telephone: (501) 371-2640 or 1(800) 852-5494**

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MANAGED CARE PROVISIONS	X
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## SCHEDULE OF ELIGIBLE CLASSES

A person may be insured under only one eligible class as set forth herein though he or she may be eligible under more than one class. Also, a person may not be insured as a Dependent and an Insured at the same time.

**[Class 1:** All full-time [and part-time] Domestic Students enrolled in and engaged in educational activities at Policyholder who cannot provide proof of an equal or better insurance plan will automatically be billed for coverage in the student health insurance plan.

**Class 2:** All full-time [and part-time] International Students or other persons possessing and maintaining a current passport and valid visa status (F-1, J-1 or M-1 etc.) engaged in educational activities at Policyholder who are temporarily located outside their Home Country and have not been granted permanent residency status are required to be insured under this Policy.

**Class 3:** All full-time [and part-time] Domestic [and International Students] enrolled in Policyholder while traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

**Class 4:** Dependents of Insureds as defined in the Definition Section of this Policy.]

[To be a Covered Person under this Policy, the person must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the Policyholder to Us. All Insureds must actively attend classes for the first 45 consecutive days following their effective date for the term purchased and/or pursuant to their visa requirements for the period for which coverage is purchased except in the case of medical withdrawal or during school authorized breaks. ]

We maintain Our right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that the Policy eligibility requirements have not been met, Our only obligation is a pro-rata refund of premium.

**SCHEDULE OF BENEFITS**

Unless otherwise specified, Benefit Maximums apply on a per Covered Person, per Covered Accident/Covered Sickness basis.

Total Benefit Maximum for all Covered Expenses per covered Accident/Sickness: [\$50,000, \$100,000, \$250,000, \$500,000 or \$1,000,000]

Preferred Provider Deductible: [\$50, \$100, \$250, \$500, \$1,000] per Covered Person  
 Out-of-Network Deductible: [\$50, \$100, \$250, \$500, \$750, \$1,000] per Covered Person  
 [The Deductible is waived for the following Benefits:

]

**COVERAGE**

**BENEFIT AMOUNT**

**HOSPITAL EXPENSE BENEFIT**

Hospital Room & Board Expense Covered Percentage

Preferred Provider:	[80%, 90%, 100%] of Preferred Allowance
Out-of-Network:	[50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum:	Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum
------------------	--

Miscellaneous Hospital Expense Covered Percentage

Preferred Provider:	[80%, 90%, 100%] of Preferred Allowance
Out-of-Network:	[50%, 60%, 70%] of Reasonable Customary

Benefit Maximum:	Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum
------------------	--

**SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)**

Inpatient Surgery Expense Covered Percentage

Preferred Provider:	[80%, 90%, 100%] of Preferred Allowance
Out-of-Network:	[50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum:	Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum
------------------	--

Outpatient Surgery Expense Covered Percentage

Preferred Provider:	[80%, 90%, 100%] of Preferred Allowance
Out-of-Network:	[50%, 60%, 70%] of Reasonable & Customary

Multiple Surgical Procedure Expense Covered Percentage:	Paid according to Policy language
Anesthesia Expense Covered Percentage:	[10%, 20%, 25%] of the paid Surgical Expense

Assistant Surgeon Expense Covered Percentage: [10%, 20%, 25%] of the paid Surgical Expense

**IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$250, \$500, \$1,000] per day with 30 day maximum

**OUTPATIENT EXPENSE BENEFIT**

Doctor's Office Visit Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Co-payment: [\$10, \$15, \$20, \$25] for Preferred Provider;  
[\$15, \$20, \$25, \$30] for Out-of Network provider

Chiropractic Care Office Visit Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$250, \$500, \$1,000, \$2,000] per Policy Year

Emergency Room Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%, 80%] of Reasonable & Customary for a Medical Emergency and [50%, 60%, 70%] of Reasonable & Customary for all other

Co-payment: [\$25, \$35, \$45, \$50, \$75, \$100, \$150] [(waived if admitted)]

Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Co-payment: [\$15, \$20, \$25] per condition  
Benefit Maximum: [\$500, \$750, \$1,000] per condition

[Physical Therapy Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$40, \$50, \$60, \$70] per visit, one visit per day with a 10 visit maximum]

[Speech Therapy Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

[Acupuncture Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

Benefit Maximum: [\$500, \$750, \$1,000] per Policy Year]

[Shots & Injections in a Doctor's Office Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

**MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum [\$10,000, \$25,000] per Policy Year

Outpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$40, \$50, \$60, \$70] per visit with a [\$500, \$1000, \$1500] per condition, per Policy Year

**SERIOUS MENTAL ILLNESS EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Outpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**ALCOHOL & DRUG ABUSE EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$5,000, \$10,000, \$15,000, \$25,000] per Policy Year

Outpatient Expense Covered Percentage: [80%, 90%, 100%] of Preferred Allowance  
Preferred Provider: [50%, 60%, 70%] of Reasonable & Customary  
Out-of-Network:

Benefit Maximum: [\$2,500, \$5,000 \$10,000] per Policy Year

Benefit maximum for the treatment for withdrawal from the psychological effects of alcohol or drugs: [\$1,500, \$2,500, \$5,000] per Policy Year

**[MATERNITY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[RECONSTRUCTIVE BREAST SURGERY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[ACCIDENTAL DEATH & DISMEMBERMENT**

Principal Sum: [\$2,500, \$5,000, \$10,000, \$25,000 or \$50,000] [(Insured only)] ]

**[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT**

Covered Percentage Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$200 per tooth or \$500, \$750, \$1,000] [\$2000] per Policy year]

**[AMBULANCE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$500, \$750, \$1,000] per Policy Year]

**[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$1000, \$2,500, \$5,000] per Policy Year]

**[HOME HEALTH CARE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [50, 75,100] visits per calendar year]

**[LICENSED NURSE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[HOSPICE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[PRE-ADMISSION TESTS EXPENSE BENEFIT**

Covered Percentage: Paid under Hospital Miscellaneous]

**[PRESCRIPTION DRUG EXPENSE BENEFIT**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Co-payment: Brand Name Drugs: [\$10, \$20, \$25, \$30] per prescription  
Generic Name Drugs: [\$5, \$10, \$15, \$20] per prescription

Benefit Maximum: [\$250, \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$5,000] per Policy Year]

**[CLINICAL TRIAL OR STUDY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%,100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[INHERITED METABOLIC DISEASE EXPENSE BENEFIT**

Covered Percentage: Preferred Provider [80%, 90%,100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$2,500, \$5,000, \$7,500] per Policy Year for Special Food Products]

**[DIABETES SELF MANAGEMENT PROGRAM EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

**[COLORECTAL CANCER SCREENING EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[WELL BABY EXAMINATIONS AND CHILDHOOD IMMUIZATIONS EXPENSE BENEFIT**

Covered Percentage: Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[HOME COUNTRY EXTENSION BENEFIT**

Period of Coverage [30, 60 Days] ]

**[REPATRIATION OF REMAINS BENEFIT**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Benefit Maximum: [\$5,000, \$10,000, \$15,000, \$20,000, \$25,000] ]

**[EMERGENCY MEDICAL EVACUATION BENEFIT]**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Benefit Maximum: [\$10,000, \$25,000, \$50,000]]

**[INTERCOLLEGIATE SPORTS COVERAGE**

Maximum per Injury: [\$1,500 ]  
Maximum per Tooth: [\$150] ]

**[SCHEDULE OF PREMIUM RATES**

[Student [From Date to Date]  
Spouse [\$0000.00]  
[\$0000.00]

STAH-GL-P

Child(ren)

[\$0000.00]]

Premiums received by Us are fully earned upon receipt. In addition to the eligibility requirement specified in the Eligibility for Insurance provision, refund of premiums will be considered only: 1) for Insureds withdrawing from a Study Abroad Program entirely before the departure date; or 2) for a Covered Person entering the Armed Forces of any country. Such person will not be covered under the Policy as of the date of his or her entry into to Armed Forces. A refund of unused premium will be made for such person with 90 days of withdrawal from the Policyholder when written notice is received by Us. No other refunds will be made. ]

## **DEFINITIONS**

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**“Accident”** means a sudden, unexpected and unintended event.

**“Covered Accident”** means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

**“Coinsurance”** means the percentage of Reasonable and Customary Charges for which the Covered Person is responsible for a covered service.

**“Complications of Pregnancy”** means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion).

**“Co-payment”** means the specified dollar amount a Covered Person must pay for specific charges. The co-payment is separate from and not a part of the Deductible or Coinsurance.

**“Covered Allowance”** means that part of the Covered Expenses that is payable by the Company after the Deductible or Co-payment has been met.

**“Covered Expenses”** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply was rendered or obtained.

**“Covered Loss” or “Covered Losses”** means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy.

**“Covered Percentage”** means that part of the Covered Expenses that is payable by the Company after the Deductible or Co-payment has been met.

**“Covered Person”** means any Insured [and Dependent] who enrolls for coverage and for whom the required premium is paid.

**“Deductible”** means the amount of Covered Expenses for Covered Expenses and supplies which must be incurred by the Covered Person before specified benefits become payable.

**[“Dependent”** means (a) the Insured's spouse residing with the Insured; [the Insured's Domestic Partner;] or (b) the Insured's unmarried children under the age of nineteen (19) years [or through the age of 25 if they are full-time students at an accredited school]. Children must be fully supported by the Insured. Coverage for newborn children will consist of coverage for Sickness or Accident including necessary care or treatment of congenital defects, birth abnormalities,

premature birth and routine nursery care. Such coverage will start from the moment of birth if the Insured is already insured for dependent coverage when the child is born. If the Insured does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth or any minor child placed with an Insured for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured for adoption. To continue the newborn child's dependent benefits past the first 31 days, the Insured must notify Us in writing within 31 days of the child's birth.

The term "children" includes an Insured's biological children, step-children, adopted children from the date of placement in the Insured's home and who depend on the Insured for their full support.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of a physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured must send proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age. ]

**"Doctor"** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a Covered Person's Immediate Family Member or household.

**["Domestic Partner"** means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Covered Person has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

**["Domestic Partnership"** means a relationship between the Covered Person and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

- (a) [They share the same permanent residence and the common necessities of life;
- (b) They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- (c) Each is at least 18 years of age;
- (d) Each is mentally competent to consent to contract;
- (e) Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
- (f) They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - (1) have a single dedicated relationship of at least 6 months duration;
  - (2) joint ownership of residence;
  - (3) at least two of the following:
    - (i) joint ownership of an automobile;
    - (ii) joint checking, bank or investment account;
    - (iii) joint credit account;
    - (iv) lease for a residence identifying both partners as tenants;
    - (v) a will and/or life insurance policies which designates the other as primary beneficiary.
- (g) The Covered Person and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

**"Domestic Student"** is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

**“Effective Date”** means the first date a student becomes covered under the Policy.

**“Elective Treatment”** means medical treatment which is not necessitated by a pathological change in the function or structure of any part of the body occurring after a Covered Person’s coverage goes into effect.

Elective Treatment includes, but is not limited to: tubal ligation, vasectomy, breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine examinations.

**“Experimental or Investigational Care”** means a service or supply:

- (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
- (b) which requires approval by any government authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

**“Home Country”** means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country which the Covered Person has declared to Us in writing as his or her Home Country.

**“Hospital”** means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place solely for the aged.

**“Hospital Confined”** means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

**“Immediate Family Member”** means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son- or daughter-in-law; and brother- or sister-in-law.

**“International Student”** is a student classified as a Non-Immigrant. For example, students holding visa types: “F” (Student), “J” (Exchange Visitor), “B” (Tourist) or “A” (Diplomat).

**“Injury”** means accidental bodily harm sustained by a Covered Person from a Covered Accident that results directly and independently from all other causes. [The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. ]

**“Insured”** means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. [An Insured is not a Dependent covered under the Policy. ]

**“Medical Emergency”** means the unexpected onset of an Injury or Sickness that requires immediate or urgent medical attention to avoid death or serious permanent damage to the body, or pain sufficient to warrant immediate care. It does not include elective or routine care.

**“Medically Necessary”** means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Covered Person or provider;
- (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Doctor may prescribe, order, recommend or approve a service or supply does not, itself, make the service or supply Medically Necessary.

**“Out-of Network Providers”** have not agreed to any pre-arranged fee schedules.

**“Policy Effective Date”** means the date the Policy takes effect as indicated on the face page of this Policy.

**“Policy Termination Date”** means the date the Policy ends, as indicated on the face page of this Policy.

**“Policy Year”** means the 12 month period beginning on the Policy Effective Date.

**“Preferred Allowance”** means the amount a Preferred Provider will accept as payment in full for Covered Expenses.

**“Preferred Providers”** are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

**“Reasonable and Customary Charge”** means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

**“Sickness”** [means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness].

**“Trip”** means travel by air, land or sea from the Covered Person’s Home Country.

**“We”, “Our”, “Us”** means the insurance company underwriting this insurance.

**“You” and “Your”** mean the Policyholder.

## **ELIGIBILITY FOR INSURANCE**

Each person within one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any unused premium paid for that person.

In no event will a dependent be eligible if the Insured is not eligible.

### **EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL**

This Policy takes effect as of the Policy Effective Date as indicated on the face page of this Policy. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided herein, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on any anniversary date of the Policy Effective Date. We will give the Policyholder at least sixty (60) days prior written notice. We also reserved the right to refuse to renew this Policy.

However, in no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.

### **EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE**

Insurance under the Policy will become effective at 12:01 a.m. on the latest of:

1. the Policy Effective Date;
2. the beginning date of the term for which premium has been paid;
3. the day after and enrollment form (if applicable) and premium payment are received by Us, the Policyholder or the plan administrator;
4. the day after the date of postmark if the enrollment form is mailed;
5. For international students and scholars, the date the Cover Person departs his or her Home Country to travel to the country of assignment provided that the scheduled arrival in the country of assignment is no more than 48 hours later than the departure from the Home Country (except for school authorized breaks).

[Coverage for Dependents will become effective at 12:01 a.m. on the latest of:

1. the Policy Effective Date;
2. the beginning date of the term for which premium has been paid; or
3. the day after the date the required individual enrollment form and premium payment are received by Us, the Policyholder or the plan administrator when premium payment is made within 31 days of the student's enrollment in the Policyholder's insurance plan. ]

### **[LATE ENROLLMENT FOR DEPENDENTS**

An Insured may add his or her Dependent as a late enrollee:

1. when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester or pro-rated premium is required even if the spouse is enrolled after the term has begun;
2. when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application for coverage must be submitted within 31 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun; and

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3. when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun.

If the Insured does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage. ]

### **TERMINATION DATE OF INSURANCE**

An Insured's coverage will end on the earlier of the date:

1. the Policy terminates;
2. the Insured is no longer eligible;
3. the period ends for which premium is paid;
4. the date the Insured enters military service in which case a pro-rata refund of premium will be made to the Insured;
5. the Insured leaves the Policyholder, and cancels his or her coverage;
6. the last day the Insured is required to be on campus at the Policyholder and/or returns to his or her Home Country, except for Insureds traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

Termination of Insurance for an Insured shall be without prejudice to any claim which starts prior thereto.

[A Dependent's coverage will end on the earliest of the date:

1. the or she is no longer a Dependent;
2. the Insured's coverage ends;
3. the period ends for which premium is paid;
4. the last day the Insured is required to be on campus at the Policyholder and/or returns to his or her Home Country, except for Insureds traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder. ]

### Certificates of Creditable Coverage

We will provide written certification of coverage to the Insured which certifies the length of:

1. The period of credible coverage that the person accumulated under the plan and any coverage under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 as that act existed on July 16, 1997, relating to the continuation of coverage; and
2. Any waiting and affiliation period imposed on the Insured pursuant to that coverage.

The certification of coverage will be provided to the Insured who was insured:

1. At the time he or she ceases to be covered under the plan if he or she does not otherwise become covered under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, as that act existed on July 16, 1997, relating to the continuation of coverage;
2. If he or she becomes covered under such a provision at the time that he or she ceases to be covered by that provision; and
3. Upon request, if the request is made not later than 24 months after the date on which he or she ceased to be covered as described in paragraphs (1) and (2) above.

## EXTENSION OF BENEFITS

We will extend benefits under the Policy for [30, 60, 90] days after a Covered Person's coverage would otherwise end if on that date he or she is:

1. Hospital Confined for an Injury or Sickness covered by the Policy; and
2. under a Doctor's care.

Any Benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits.

## [RENEWABILITY OF COVERAGE

A student who is enrolled as a regular undergraduate or graduate student at the Policyholder will be provided with continuous coverage under this Policy for himself or herself and his or her Dependents each subsequent year the Policyholder renews this Policy with Us. Once an Insured has been covered under this Policy and satisfied any Pre-existing Condition Limitation exclusion period, if applicable, coverage under this Policy will be considered continuous. The student must apply for coverage and pay premiums as described in the Policy. ]

## PRE-EXISTING CONDITION

**"Pre-existing Condition"** means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the [6 -12] months immediately preceding the Effective Date of the Insured's coverage under this Policy. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

The **"Pre-existing Condition Waiting Period"** is [6 - 12] months. If an Insured receives treatment or service for a Pre-Existing Condition: (a) We will not pay benefits for such condition until the day after a [6 – 12] consecutive month period has passed from the Insured's effective date; and (b) We will pay only for Covered Expenses incurred after such [6 – 12] consecutive month period.

The Pre-existing Condition Waiting Period will be reduced by the aggregate period of credible coverage of the Insured if the Credible Coverage was continuous to a date not more than 63 days before the Effective Date of coverage.

Payment will be in accord with the provisions of this Policy. If the Insured has a lapse in coverage for more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

The Pre-existing Condition Waiting Period will not apply:

1. [To pregnancy];
2. In the case of an Insured who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage;
3. In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.
4. In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured held Creditable Coverage and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

The provisions of paragraphs (2) and (3) do not apply to an Insured after the end of the first 63-day period during all of which the Insured was not covered under any Creditable Coverage.

**“Creditable Coverage”** means health benefits or coverage provided to a person pursuant to:

1. A group health plan;
2. A health benefit plan;
3. Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395c et seq., also known as Medicare;
4. Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec. 1396s;
5. The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefit risk pool;
8. A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seq.;
9. A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
10. A health benefit plan under Sec. 5(e) of the Peace Corps Act, U.S.C. Sec. 2504(e);
11. The children’s health insurance program established pursuant to 42 U.S.C. Sec. 1397aa to 1397jj, inclusive;
12. A short-term health insurance policy; or
13. A blanket accident and health insurance policy.

## MANAGED CARE PROVISIONS

This Policy provides benefits based on the type of health care provider the Insured or his or her Dependents selects. This Policy provides access to both Preferred Providers and worldwide coverage for Out-of-Network Providers.

This Policy will pay the Covered Percentage of the Preferred Allowance for Covered Expenses if the Insured [or his or her Dependents] uses a Preferred Provider. This Policy will pay the Covered Percentage of the Reasonable and Customary Charge for Covered Expenses if an Out-of-Network Provider is used. All payments will be subject to any applicable Deductible, Co-insurance, Maximum Benefits and other provisions or limitation in this Policy. Covered Expenses are payable in accordance with the Schedule of Benefits.

Use of Preferred Providers offers better benefits for the Insured. Out-of-Network Provider services are subject to the Deductible and higher Co-insurance. Refer to the Schedule of Benefits for a complete description of coverage.

The Insured should be aware that Preferred Provider Hospitals may be staffed with Out-of-Network Providers. It is important that the Insured verify that his or her Doctors are Preferred Providers each time he or she calls for an appointment or at the time of service.

In the event a Covered Person is receiving medical treatment from a Preferred Provider and the Preferred Provider's contract is terminated during the course of medical treatment, then:

1. The Covered Person may continue to obtain medical treatment for the medical condition from the medical provider under the Preferred Provider contract if:
  - a. the Covered Person is actively undergoing a medically necessary course of treatment; and
  - b. the medical provider and the Covered Person agree that continuity of care is desirable.
2. The medical provider is entitled to receive reimbursement for the medical treatment if the medical provider agrees to:
  - a. to provide medical treatment to the Covered Person under the same terms, including, without limitation, the rates of payment, that existed before the termination of the Preferred Provider contract; and
  - b. not to seek payment from the Covered Person for any medical service provided by the medical provider that the medical provider could not have received if the medical provider were still under the Preferred Provider contract.
3. Coverage required by this section must be provided until the later of:
  - a. the 120<sup>th</sup> days after the date the Preferred Provider contract is terminated; or
  - b. if the medical condition is pregnancy, the 45<sup>th</sup> day after:
    - i. the date of delivery; or
    - ii. if the pregnancy does not end in delivery, the date of the end of the pregnancy.
4. The requirements in this section do not apply if:
  - a. The Preferred Provider contract was terminated due to the medical incompetence or professional misconduct of the medical provider; and
  - b. No new Preferred Provider contract was entered into with the medical provider.

### Deductible, Coinsurance and Co-payment Rules

**Deductible:** The Insured's Deductible applies to all Preferred Provider and Out-of-Network Provider Covered Expenses unless specified otherwise in this Policy.

**Coinsurance/Co-payments:** Some covered services are subject to Coinsurance and Co-payments. This is the amount the Insured must pay to the Doctor or Hospital for each procedure, visit or confinement each time he or she receives a covered service including prescription drugs. The Coinsurance is not applied until after the Insured has paid any applicable Deductible that may be required under this Policy. What We pay is shown in the Schedule of Benefits.

**Waiver of Co-payment:** The Emergency Room Co-payment will be waived if the Insured is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured received Medical Emergency care.

Certain medical procedures or treatments will require a prior notification request form to be received by the Company or the Company's authorized representative a minimum of 5 business days prior to the scheduled procedure date and approval must be received prior to the commencement of the proposed medical treatment. Prior notification is also required for any procedure or treatment that the Covered Person's Doctor anticipates will exceed \$1,000.

Services requiring prior authorization are:

1. All Inpatient admissions and/or treatments;
2. Any surgeries requiring general anesthesia (Outpatient or Inpatient)
3. [Accidental Dental treatment (for emergency dental repair of natural sound teeth damaged in an accident;]
4. [Purchase or rental of Durable Medical Equipment;]
5. [Home Health Care;]
6. [RSV Immunization and other medications priced in excess of \$1,000 per refill;]
7. All cancer treatments/therapies;
8. Hemodialysis and Peritoneal Dialysis for renal failure;
9. Substance Abuse treatments/therapies;
10. Any condition, including chronic conditions that do not meet the above criteria, but are expected to accumulate over \$1,000 in Covered Expenses per Policy Year.

## DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy.

### **ACCIDENT EXPENSE BENEFIT**

When, by reason of Injury, a Covered Person incurs expenses for hospital, surgical or medical treatment, services or supplies including while traveling outside their Home Country for [up to 365 days] to engage in educational or cultural activities sponsored by the Policyholder, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

[Covered Expenses must be incurred within [52 weeks] after the date of the Accident.]

What We pay is shown in the Schedule of Benefits.

### **SICKNESS EXPENSE BENEFIT**

When, by reason of Sickness, a Covered Person incurs expenses for hospital, surgical or medical treatment, services or supplies including while traveling outside their Home Country for [up to 365 days] to engage in educational or cultural activities sponsored by the Policyholder, We will pay for the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

[Covered Expenses must be incurred within [52 weeks] after the date of the Sickness. ]

What We pay is shown in the Schedule of Benefits.

### **HOSPITAL EXPENSE BENEFIT**

#### **Part A: Hospital Room and Board Expense**

When, by reason of Injury or Sickness, a Covered Person is required to be Hospital Confined, We will pay the Covered Percentage of the Hospital room and board Covered Expense for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a newborn nursery, special care or intensive care unit.

#### **Part B: Miscellaneous Hospital Expense**

“Miscellaneous Hospital Expense” includes expenses incurred for:

1. anesthesia, anesthesia supplies and services;
2. operating, delivery and treatment rooms and equipment;
3. diagnostic x-ray and laboratory tests;
4. lab studies;
5. oxygen tent;
6. blood and blood services;
7. prescribed drugs and medicines;
8. medical and surgical dressings, supplies, casts and splints;
9. radiation therapy, intravenous chemotherapy, kidney dialysis and inhalation therapy;
10. chemotherapy treatment with radioactive substances;
11. intravenous injections and solutions and their administration;
12. physical therapy; and
13. other necessary and prescribed Hospital expenses.

We will pay the Coverage Percentage of the Covered Expenses incurred by the Covered Person during the period of Hospital Confinement for a Surgical procedure performed on an outpatient basis. What We pay is shown in the Schedule of Benefits.

## **SURGICAL EXPENSE BENEFIT**

### **Part A: Surgery Expense Benefit**

When, by reason of Injury or Sickness, a Covered Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Expenses of the Surgical Expense in connection with any one Surgical Procedure. What We pay is shown in the Schedule of Benefits.

#### **Definitions:**

**“Surgical Expense”** means charges by a Doctor for:

1. a Surgical Procedure;
2. necessary preoperative treatment during a Hospital stay in connection with such procedure; and
3. usual post-operative treatment.

**“Surgical Procedure”** means:

1. a cutting procedure;
2. suturing of a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. radiotherapy;
6. electrocauterization;
7. diagnostic and therapeutic endoscopic procedures;
8. injection treatment for hemorrhoids and varicose veins;
9. an operation by means of a laser beam.

### **Part B: Multiple Surgical Procedures Expense Benefit**

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Expense of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to fifty percent (50%) of the Covered Percentage of the Covered Expense for these procedures.

### **Part C: Anesthesia Expense Benefit**

If, in connection with such operation, the Covered Person requires the services of an anesthetist, We will pay the expense incurred, but We will not pay more than the Covered Percentage of Covered Expenses. What We pay is shown in the Schedule of Benefits.

### **Part D: Assistant Surgeon Expense Benefit**

If, in connection with such operation, the Covered Person requires the services of an Assistant Surgeon, We will pay the expense incurred, but We will not pay more than the Covered Percentage of the Covered Expenses. What We pay is shown in the Schedule of Benefits.

## **IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Covered Person, We will pay the Covered Percentage of the Covered Charges incurred for such services.

The following medical services performed by a Doctor are covered on an inpatient basis:

1. one Doctor visit per day;
2. constant care and treatment while a Covered Person is confined in an intensive care unit;
3. care by two or more Doctors during one Hospital stay when the Covered Person's condition requires the skill of separate Doctors;

4. consultation by another Doctor when request by the Covered Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.

What we Pay is shown in the Schedule of Benefits.

### **OUTPATIENT EXPENSE BENEFIT**

If, by reason of Injury or Sickness, a Covered Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility or other similar facility licensed by the state, We will pay the Covered Percentage of Covered Expenses incurred as shown in the Schedule of Benefits. What We pay is shown in the Schedule of Benefits.

#### **Outpatient Services**

Covered Expenses for "**Outpatient Services**" include the following services:

1. a Doctor's office while not Hospital Confined ;
2. [chiropractic care up to the maximum shown in the Schedule of Benefits;]
3. a Hospital outpatient department or emergency room;
4. diagnostic x-ray and laboratory testing;
5. blood and blood services if provided and billed by a Hospital or other facility;
6. [physical therapy as shown in the Schedule of Benefits;]
7. radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;
8. radiological lab or other similar facility licensed by the state;
9. surgical dressings, splints, casts and other devices used to correct fractures and dislocations;
10. [speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment after corrective surgery or following an Injury or Sickness other than a mental or learning disorder. Speech therapy must be in keeping with a Doctor's written order for type, frequency and duration;]
11. [shots or injections when received in the Doctor's office;]
12. [acupuncture up to the maximum shown in the Schedule of Benefits.]

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

With regard to a Doctor's office visit for gynecological or obstetrical services, a women is not required to first receive authorization or a referral from her primary care physician.

### **MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT**

If a Covered Person requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

#### **Benefits for Inpatient Hospital Confinement**

When a Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Covered Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility, including Hospitals. What We pay is shown in the Schedule of Benefits.

#### **Benefits for Outpatient Services**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of Mental and Nervous Conditions.

The Mental and Nervous Condition must, in the professional judgment of health care providers, be treatable and the treatment must be Medically Necessary.

Outpatient Treatment and Doctor services include charges made by an outpatient treatment department of a Hospital, community mental health facility if approved by the joint commission on accreditation of healthcare organizations or charges for services rendered in a Doctor's office. Treatment may be provided by any properly licensed Doctor, psychologist, a professional clinical counselor, professional counselor, independent social worker, clinical nurse specialist with a specialty in mental health, marriage and family therapist or other provider as required by law. What We pay is shown in the Schedule of Benefits.

**Definition**

**“Mental or Nervous Condition”** means those conditions listed in the standard nomenclature of the American Psychiatric Association.

**SERIOUS MENTAL ILLNESS EXPENSE BENEFIT**

When a Covered Person requires Hospital Confinement or outpatient services for the treatment of a Serious Mental Illness, We will pay the Covered Percentage of the Covered Expenses incurred on the same basis as any other Sickness.

Benefits are available for 30 days of Inpatient hospitalization and 60 days of outpatient medical treatment per Policy Year, excluding visits for the management of medications and that 2 visits for partial or respite care, or a combination thereof, may be substituted for each 1 day of hospitalization not used by the Covered Person.

**Definitions:**

**“Serious Mental Illness”** means any of the following biologically based mental illnesses:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Bipolar disorder;
4. Major Depressive disorder;
5. Paranoia and other psychotic disorders;
6. Panic disorder;
7. Obsessive-compulsive disorder;
8. Anorexia Nervosa;
9. Bulimia Nervosa; and
10. Delusional Disorder

**ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT**

If a Covered Person requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

**Benefits for Inpatient Confinement**

When the Covered Person is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Covered Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility by the Health Division of the Department of Health and Human Services.

What We pay is shown in the Schedule of Benefits.

### **Benefits for Outpatient Services**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency.

Outpatient Treatment and Doctor services include charges for services rendered in a Doctor's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility so long as the Hospital, community mental health facility, or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Doctor or a licensed psychologist who certifies every three months that the Covered Person needs to continue such treatment.

What We pay is shown in the Schedule of Benefits.

### **Definitions**

**"Alcohol Abuse"** means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

**"Drug Abuse"** means a condition which is characterized by a pattern of pathological use of a drug with repeated attempts to control its use and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

**"Detoxification Facility"** means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

1. monitoring the amount of alcohol and other toxic agents in the body of the individual;
2. managing withdrawal symptoms; and
3. motivating the individual to participate in the appropriate addiction treatment programs for Alcohol or Drug Abuse.

### **[MATERNITY EXPENSE BENEFIT**

We will pay benefits for a Covered Person's Covered Expenses for maternity care including routine tests, screening exams and Complications of Pregnancy for Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility unless the attending Doctor in consultation with the mother makes a decision for an earlier discharge from the Hospital.

For a mother and newborn child who remain in the Hospital for a minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for one home visit scheduled within 24 hours after Hospital discharge and an additional home visit if prescribed by an attending provider.

[Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.]

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

We cover such charges the same way We treat Covered Expenses for any other Sickness.

What We pay is shown in the Schedule of Benefits.]

#### **MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for mammographic exams. The charges must be incurred while the Covered Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

1. Any Mammogram based upon a Doctor's recommendation for women under 40 years of age; and
2. One Mammogram every twelve months for a woman 40 years of age or older or more frequently upon recommendation of a Doctor;

We cover such charges the same way We treat Covered Expenses for any other Sickness. A women is not required to first receive authorization or a referral from her primary care physician.

What We pay is shown in the Schedule of Benefits.

#### **Definition**

**"Mammogram"** means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression devise, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

#### **RECONSTRUCTIVE BREAST SURGERY EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for Reconstructive Breast Surgery the same as any other Sickness for a Covered Person's reconstructive surgery incident to a covered mastectomy. Benefits shall include reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment for any physical complications for all states of mastectomy including lymphedemas in a manner determined with the Doctor and the Covered Person.

If the reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the Policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all the terms, conditions and exclusions contained in the Policy at the time of the reconstructive surgery.

**"Reconstructive Surgery"** means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

#### **CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT**

We cover charges for Expenses incurred for an annual Cytologic Screening (Pap Smear) for women 18 years of age or older or more frequently when recommended by a Doctor, nurse practitioner or a certified nurse midwife. Such benefits will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.

We cover such charges the same way We treat Covered Expenses for any other Sickness. A women is not required to first receive authorization or a referral from her primary care physician.

What We pay is shown in the Schedule of Benefits.

**Definition**

“**Cytologic Screening**” means a pap test to detect cervical cancer through the simple microscope examination of cells scraped from the surface of the cervix.

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS [(Insured Only)]**

If Injury to the Covered Person results in any one of the losses shown below, We will pay the Benefit Amount shown below for that loss. [Loss must occur within [90 days] of the date of the accident which caused the loss.] The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Accident.

Covered Loss	Benefit Amount
Life .....	100% of the Principal Sum
Two or more Members.....	100% of the Principal Sum
One Member.....	50% of the Principal Sum

“**Member**” means Loss of Hand or Foot, and Loss of Sight. “**Loss of Hand or Foot**” means complete Severance through or above the wrist or ankle joint. “**Loss of Sight**” means the total, permanent Loss of Sight of one eye. “**Severance**” means the complete separation and dismemberment of the part from the body.]

**[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT**

We will pay the Covered Percentage of Covered Expenses incurred as a result of an accidental dental injury. What We pay is shown in the Schedule of Benefits.]

**[AMBULANCE EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

What We pay is shown on the Schedule of Benefits.]

**[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT**

If, by reason of Injury or Sickness, a Covered Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for such Durable Medical Equipment. We pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is Our property and is to be returned to Us, at Our expense, upon completion of the Covered Person’s need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

What We pay is shown in the Schedule of Benefits.

**Definition**

**“Durable Medical Equipment”** means medical equipment that: 1) is prescribed by the Doctor who documents the necessity for the item including the expected duration of its use; 2) can withstand long term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision. ]

**[HOME HEALTH CARE EXPENSE BENEFIT**

We will cover charges for Home Health Care services furnished to a Covered Person. Such benefits must be provided by a licensed Home Health Agency. Except for a home health aid, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aid shall be considered as one home health visit.

Charges for such services are not subject to the Deductible. What We pay is shown in the Schedule of Benefits.

**Definitions**

**“Home Health Care”** means the continued care and treatment of a Covered Person who is under the direct care and supervision of a Doctor but only if: (a) continued hospitalization would have been required if Home Health Care were not provided; (b) the home health treatment plan is established and approved by a Doctor within 14 days after an inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Covered Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

**“Home Health Services”** Consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Policy if the Covered Person had remained in the Hospital.

**“Home Health Agency”** means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Health and Safety Code.]

**[HOSPICE EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for Hospice Care. What We pay is shown in the Schedule of Benefits.]

**LICENSED NURSE EXPENSE BENEFIT**

If by reason of Injury or Sickness, a Covered Person requires the services of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Expenses incurred. What We pay is shown in the Schedule of Benefits.

**[PRE-ADMISSION TESTS EXPENSE BENEFIT**

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Expenses made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to a Covered Person’s admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Covered Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Covered Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Schedule of Benefits for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provided for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Covered Person only to the extent that the Covered Person is insured under this Policy for Hospital Expense Benefits. What We pay is shown in the Schedule of Benefits.]

#### **[PRESCRIPTION DRUG EXPENSE BENEFIT**

If by reason of Injury or Sickness, a Covered Person requires drugs, We will pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for such drugs and the Medically Necessary services associated with the administration of such drugs subject to the Co-payment shown in the Schedule of Benefits.

The drugs must be prescribed by a Doctor. Coverage includes any type of drug or device for contraception and any type of hormone replacement therapy which is lawfully prescribed or ordered by a Doctor and which has been approved by the Food and Drug Administration.

We only cover drugs which are approved for the treatment of the Covered Person's Injury or Sickness by the Food and Drug Administration.

We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established referenced compendia:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopoeia Drug Information; or
4. it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

However, Covered Expenses do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Coverage for prescription drugs will not be limited or excluded if the drug:

1. had previously been approved for coverage for a Covered Person's medical condition and the Covered Person's medical provider determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved are medically appropriate for the Covered Person; and
2. is appropriately prescribed and considered safe and effective for treating the Covered Person's medical condition.
3. The provisions of 1 and 2 above do not:
  - a. apply to any drug that is prescribed for a use different from the use for which that drug has been approved for marketing by the Food and Drug Administration;
  - b. prohibit charging a Deductible, Co-payment or Coinsurance or from establishing maximum benefits covered under the Policy; or

- c. a medical provider from prescribing another drug that is medically appropriate for the Covered Person.

What We pay is shown in the Schedule of Benefits.]

**[CLINICAL TRIAL OR STUDY EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person receives medical treatment as part of a clinical trial or study, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits if:

1. the medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;
2. the clinical trial or study is approved by:
  - a. an agency of the National Institutes of Health as set forth in 42 U.S.C. section 281(b);
  - b. a cooperative group;
  - c. the Food and Drug Administration as an application for a new investigational drug;
  - d. the United States Department of Veterans Affairs; or
  - e. the United States Department of Defense;
3. in case of:
  - a. a phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical studies for the treatment of cancer; or
  - b. A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a medical provider with qualified personnel having experience and training to provide the treatment in a capable manner.
4. There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;
5. There is no reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study is conducted in the Policyholder's state of domicile; and
6. The Covered Person has signed, before his participation in the clinical trial or study, a statement of consent indicating that he or she has been informed of, without limitation;
  - a. the procedure to be undertaken;
  - b. alternative methods of treatment; and
  - c. the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

Coverage for medical treatment under by this section is limited to:

1. coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the Covered Person.
2. reasonably necessary costs for health care services.
3. the initial consultation to determine if the Covered Person is eligible to participate in the clinical trial or study.
4. Health care services to monitor the Covered Person during the clinical trial or study.
5. Medical treatment provided by the sponsor of the clinical trial or study not free of charge to the Covered Person.

Coverage for medical treatment under this section does not include:

1. any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
2. coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device.

3. health care services that are specifically excluded by this Policy regardless of whether such services are provided under the clinical trial or study.
4. extraneous expenses including, without limitation, travel, housing and other expenses.
5. any expenses incurred by a person who accompanies the Covered Person during the clinical trial or study.

What We pay is shown in the Schedule of Benefits.]

#### **[INHERITED METABOLIC DISEASE EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for certain Inherited Metabolic Diseases. Benefits will include: 1) enteral formulas for use at home that are prescribed or ordered by a Doctor as Medically Necessary and characterized by deficient metabolism, or malabsorption originating from congenital defects or defect arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and 2) [\$2,500, \$5,000, \$7,500] per Policy Year for Special Food Products which are prescribed or ordered by a Doctor as Medically Necessary.

#### **Definition**

**“Inherited Metabolic Disease”** means a disease caused by an inherited abnormality of the body chemistry of a person.

**“Special Food Product”** means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the directions of a Doctor for the dietary treatment of an Inherited Metabolic Disease. The term does not include food that is naturally low in protein.]

#### **[DIABETES MANAGEMENT AND TREATMENT EXPENSE BENEFIT**

We cover charges for Covered Expenses relating to the management and treatment of diabetes, including, without limitation, coverage for the self-management of diabetes. Diabetes includes type I, type II and gestational diabetes.

We cover such charges the same way We treat Covered Expenses for any other Sickness. What We pay is shown in the Schedule of Benefits.

Coverage for the management and treatment of diabetes includes coverage for medication, equipment, supplies and appliances that are Medically Necessary for the treatment of diabetes.

Coverage for the self-management of diabetes includes:

1. the training and education provided to the Covered Person after he or she is initially diagnosed with diabetes which is Medically Necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
2. training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Covered Person and which requires modification of his or her diabetic self management program; and
3. training and education which is Medically Necessary because of the development of new techniques and treatment for diabetes. ]

#### **[COLORECTAL CANCER SCREENING**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for screening of Colonrectal Cancer.]

**[WELL BABY CARE AND IMMUNIZATION EXPENSE BENEFITS**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for Medically Necessary preventative medical services rendered to the Insured's child up to the age of 2 enrolled as a Dependent which include:

1. physical examinations;
2. immunizations;
3. history measurements;
4. sensory scanning;
5. neuropsychiatric evaluation and development;
6. screening and assessments.

The Deductible and Coinsurance requirements shown in the Schedule of Benefits are waived. What We pay is shown on the Schedule of Benefits.]

**[HOME COUNTRY EXTENSION BENEFITS**

We will pay benefits for Covered Expenses if the Covered Person obtains follow-up treatment of an Injury or Sickness while he or she is in his or her Home Country during the course of a Trip for which a benefit is otherwise payable under the Policy.

Benefits will be paid for a period of [30-60] days from the date the Covered Person returns to his or her Home Country. Home Country Extension Benefit payments are subject to the Benefit Maximums, Covered Percentage, Deductible and Co-payment shown in the Schedule of Benefits.]

**[REPATRIATION OF REMAINS BENEFIT**

We will pay Repatriation Benefits as shown in the Schedule of Benefits for preparation and return of a Covered Person's body to his or her Home Country if he or she dies due to an Injury or Sickness. Covered Expenses include, but are not limited to:

1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains by the most direct and least costly conveyance and route possible.

Benefits will not be payable unless We authorize all expenses in advance, in writing, or by an authorized electronic or telephonic means.]

**[EMERGENCY MEDICAL EVACUATION BENEFIT**

We will pay benefits for Covered Expenses as shown in the Schedule of Benefits for a Covered Person's Emergency Medical Evacuation.

Benefits are payable if the Covered Person:

1. is traveling outside his or her Home Country;
2. suffers an Injury or Sickness during the course of the Trip; and
3. requires Emergency Medical Evacuation.

Benefits will not be payable unless:

1. the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Injury or Sickness requiring the Emergency Medical Evacuation;
2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
4. do not include charges that would not have been made if there were no insurance.

**Definitions**

**“Emergency Medical Evacuation”** means:

1. the immediate transportation from the place where the Covered Person suffers an Injury or Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or
2. transportation to your Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness.

An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation.]

**[INTERCOLLEGIATE SPORTS BENEFIT**

We will pay benefits for Covered Expenses as shown in the Schedule of Benefits if a Covered Person sustains an Injury while practicing, playing or traveling to or from an intercollegiate sports event as a member of a sports team or tryout squad are covered, up to the maximum amount shown in the Schedule of Benefits for each accident. Benefits for Injury to natural teeth will be limited to a per-tooth maximum amount.]

## COORDINATION OF BENEFITS

If a Covered Person is eligible for benefits under this policy and any other plan, We will pay benefits as explained in this provision.

### Definitions

**“Plan of Health Coverage”** means an individual or group insurance plan or an individual or group contract of a health insuring corporation providing hospital, dental, surgical or medical services or any other individual or group benefit plan or third-party payer plan providing hospital, dental, surgical or medical services. These coverages include: a) individual, group or blanket insurance coverage, or any other individual or group type contract or provision; b) service plan contracts, group practice and other pre-payment group coverage; c) any coverage under labor-management trustee plans, union welfare plans, employer and employee plans; and coverage under any government program, including Medicare, and any coverage required or provided by law. A primary plan pays benefits first. A secondary plan pays a reduced amount of benefits that when added to the benefits paid by the primary plan will not be more than the Allowable Expenses.

**“Allowable Expenses”** means any necessary, reasonable and customary item of expense, a part of which is covered by at least one of the Plans covering the Covered Person. During any Policy year or benefit period, the sum of the benefits that are payable by Us and those benefits that are payable from another Plan of Health Coverage may not be more than the Allowable Expenses. During any Policy year or benefit period, We may reduce the amount We pay so that this reduced amount plus the amount payable by the other Plan of Health Coverage will not be more than the Allowable Expenses.

Allowable Expenses under the other Plan of Health Coverage include benefits that would have been payable if a claim had been made.

However, if: 1) the other Plan of Health Coverage contains a section that provides for determining its benefits after Our benefits have been determined; and 2) the order of benefit determination stated in this Policy would require Us to determine benefits before the other Plan of Health Coverage, then the benefits of such other Plan of Health Coverage will be ignored in determining the benefits We will pay.

This Policy determines its order of benefits using the first of the following rules that applies:

1. If the other Plan of Health Coverage does not have a Coordination of Benefits, that Plan of Health Coverage pays first.
2. The benefits of the Plan of Health Coverage that covers the person as an employee, member, insured or subscriber are determined before those of the Plan of Health Coverage that covers the person as a Dependent.
3. If this Policy and another Plan of Health Coverage cover the same child as a Dependent of different parents who are not divorced or separated or divorced:
  - A. the benefits of the Plan of Health Coverage of the parent whose birthday falls earlier in the year (without regard to the year of birth) are paid before the benefits of the Plan of Health Coverage of the parent whose birthday falls later in the year;
  - B. if both parents have the same birthday, the benefits of the Plan of Health Coverage that covered the parent longer pays benefits before the benefits of the Plan of Health Coverage that covered the other parent for a shorter time.

However, if the Plans of Health Coverage do not agree on the order of benefits, the rule of the other Plan of Health Coverage will determine the order of benefits.

4. If two or more Plans of Health Coverage cover a person as a Dependent child of divorced or separated parents, benefits will be determined in this order:
  - A. first, the Plan of Health Coverage of the parent with custody of the child;
  - B. then, the Plan of Health Coverage of the spouse of the parent with custody of the child; and
  - C. finally, the Plan of Health Coverage of the parent not having custody of the child.
5. If none of the above rules determines the order of benefits, the benefits of the Plan of Health Coverage that covered an employee, member, insured or subscriber longer are determined before those of the Plan of Health Coverage that covered that person for the shorter time.

To determine how this provision should apply, We may without further consent or notice release to, or obtain from, any other insurance company or organization, any necessary information. Any person claiming benefits under the Policy shall give Us the information We need to implement this provision. We will give the Covered Person notice of this exchange of claim and benefit information when the claim is filed.

Whenever payments are made by another Plan of Health Coverage that should have been paid under the Policy, We shall pay any amount require to satisfy our share of the benefits paid. Any amounts paid in this way will be considered benefits paid under the Policy. Any payment made in good faith will end our liability to the extent of the payment.

If We pay benefits for Allowable Expenses that exceed our obligation under this provision, We may recover the excess payment. We may recover these excess payments from any person, for whom benefits were paid, or to any person or organization to which benefits were paid, or from any other insurer, service plan or other organization.

## EXCLUSIONS

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary or Hospital or by Health Care Providers employed by the Policyholder;]
2. [Preventative medicines, serums, immunizations or vaccines except as specifically provided;]
3. [Care and/or treatment in skilled nursing facility except as specifically provided;]
4. [Organ transplants;]
5. [Hospice services except as specifically provided;]
6. [Pre-existing Conditions as defined in this Policy;]
7. [Nonprescription drugs or medicines;]
8. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country except as specifically provided. Upon the Covered Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Covered Person;]
9. [Sickness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate clubs sports and professional sports[ except as specifically provided];]
10. [Injury resulting from motor vehicle accident in excess of [\$5,000, \$10,000, \$15,000, \$20,000] per Accident;]
11. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Covered Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]
12. [Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planning, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;]
13. [Correction of congenital defects except as specifically provided;]
14. [Injury of Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]
15. [Expense incurred as the result of dental treatment except as provided in the Accidental Dental Expense Benefit if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;]

16. [Expense incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision, when applicable;]
17. [Injury or Sickness resulting from declared or undeclared war or any act thereof;]
18. [Charges for treatment of any Injury or Sickness due to a Covered Person's commission of or attempt to commit a felony or a crime which would be considered a felony if prosecuted;]
19. [Injury due to participation in a riot;]
20. [Charges for which a Covered Person has no legal obligation to pay in absence of this or like coverage;]
21. [For services or supplies rendered by a close relative of the Covered Person. By "**close relative**" We mean a Covered Person's spouse, children, parents, brothers and sisters;]
22. [Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat fee; subluxation; corns, calluses; bunions except open cutting operations, routine care of toenails except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet and any tarsalgia or metatarsalgia. Expenses incurred for the care and treatment of Injury, infection or disease are not excluded;]
23. [Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination and services or supplies for inducing conception;]
24. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]
25. [Treatment for obesity including any care which is primarily dieting or exercise for weight loss except for surgical treatment of morbid obesity;]
26. [Expense incurred for eye examination or prescriptions, eyeglasses, contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, lasix or other vision procedures except as required for repair caused by a covered Injury;]
27. [Well baby care including routine exams and immunizations except as specifically provided;]
28. [Routine periodical physical examination and routine chest x-rays except as specifically provided;]
29. [Expenses incurred for allergy testing and allergy treatment;]
30. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]
31. [An amount of a charge in excess of the Reasonable and Customary Charge;]
32. [Elective Treatment or elective surgery except as specifically provided;]

33. [Services not Medically Necessary;]
34. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare paying passenger in an aircraft operating by a scheduled airline maintaining regular published schedules on a regularly established route;]
35. [Treatment of mental or nervous disorder except as specifically provided;]
36. [Treatment for alcohol and substance abuse except as specifically provided;]
37. [Suicide, attempted suicide or intentionally self-inflicted injury;]
38. [Expense incurred for: tubal ligation; vasectomy; breast implants, breast reduction, sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism and learning disabilities or disorders of Attention Deficit Disorder;]
39. [Voluntary or elective abortion; pregnancy of a dependent child;]
40. [Illegal drugs;]
41. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication, legend vitamins or food supplements, smoking deterrents, immunization agents, biological sera, drugs to promote or stimulate hair growth, experimental drugs, drugs dispensed in a rest home or hospital except as provided under the Hospital Expense Benefit;]
42. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication or for any drug which the FDA has determined to be contraindicated for a particular condition;]
43. [Testing, treatment or services for any condition in the absence of Sickness or Injury except as specifically provided;]
44. [Hearing aids, including exams for fitting except as required to correct damage caused by an Injury which occurs while the patient is covered by this Policy provided they are obtained within four months of the date of the Injury;]
45. [Expense for hair replacement, wigs or wig maintenance; or]
46. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy.]

## GENERAL PROVISIONS

**PREMIUMS** The premiums for the Policy will be based on the rates currently in force, the coverage and amount of insurance in effect.

**CHANGES IN PREMIUM RATES** We may change the premium rates from time to time with at least 60 days advanced written or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. There is a misrepresentation in the information We relied on in establishing the rate.
5. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

**PAYMENT OF PREMIUM** The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

**POLICY GRACE PERIOD** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

**ENTIRE CONTRACT; CHANGES** The entire contract is made up of: (a) this Policy, including Your application; and (b) the individual applications, if any, of Covered Persons. Statements made by the Policyholder or a Covered Person, in the absence of fraud, shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person or to his/her beneficiary. The Insured, his beneficiary or assignee has the right to make a written request to the Company for a copy of the application and the Company shall, within 15 days after the receipt of a request at its home office or any authorized agent's office, deliver or mail to the person making the request a copy of the application. If a copy is not delivered or mailed, the Company is precluded from introducing the application as evidence in any action based upon or involving any statements contained therein.

No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidence by endorsement on this Policy signed by the Policyholder and Us. No agent has authority to change this Policy or to waive any of its provisions.

**CLERICAL ERROR** If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the terms and conditions of the Policy.

**NOTICE OF CLAIM** Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any Covered Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us or to any authorized agent with information sufficient to identify the Covered Person shall be deemed notice to Us.

**CLAIM FORMS** Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of loss by giving written proof of: (a) the occurrence of the Covered Loss; (b) the nature of the Covered Loss; and (c) the extent of the Covered Loss.

**PROOF OF LOSS** Written proof of loss must be given to Us or to any authorized agent within 90 days after the date of such Covered Loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

**TIME PAYMENT OF CLAIMS** Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by Us.

**PAYMENT OF CLAIMS** All benefits other than death will be paid to the Covered Person. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. We must receive the request no later than the time for filing proof of loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured.

Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's:

1. spouse;
2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); mother or father;
3. estate.

All other benefits due and not assigned will be paid to the Covered Person, if living.

Otherwise, the benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Covered Person's estate.

If a benefit due is payable to:

1. the Covered Person's estate; or
2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment.

We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith.

The Covered Person may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Insured is the beneficiary for any covered Dependent.

**APPEALS PROCEDURE** If a claim is wholly or partially denied, a written notice will be sent to the Covered Person containing the reason for the denial. The notice will include a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal along with any additional information or comments may be sent within 6 months after notice of denial. In preparing the appeal, the Covered Person, or his/her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

**PHYSICAL EXAMINATION** At Our own expense, We have the right to have a Doctor examine a Covered Person when and so often as We deem reasonably necessary while there is a claim pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

In the event the Company, for final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any Covered Person, only a Doctor or chiropractor who is certified to practice in the same field of practice may conduct the independent evaluation. The independent evaluation must include a physical examination of the Covered Person and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of the findings must be sent to the primary treating physician or chiropractor and the Covered Person within 10 working days after the evaluation. If the Covered Person disagrees with the finding of the evaluation, he must submit an appeal to the Company pursuant to the procedure for binding arbitration set forth herein within 30 days after he receives the finding of the evaluation. The procedure for binding arbitration to resolve disputes concerning independent medical examinations shall follow the rules of the American Arbitration Association.

**LEGAL ACTIONS** No one may sue Us for payment of claim: (a) less than 60 days after due proof of claim is furnished; or (b) more than three years after the date proof of claim is required by this Policy.

**RECORDS MAINTAINED** You shall maintain records of each person insured. The records shall show all data that is needed to administer this Policy.

**REPORTING REQUIREMENT** The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. any additional information required by Us.

**EXAMINATION AND AUDIT** We shall be allowed to examine and audit Your books and records which pertain to this Policy at reasonable times. We may also be allowed to do this within 3 years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

**SUBROGATION AND RECOVERY RIGHTS** If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Covered Person will do whatever is necessary to enable Us to exercise Our right and will do nothing after to prejudice it. If We are precluded from exercising Our right to subrogation, We may exercise Our right to reimbursement.

If benefits are paid under this Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have the right to recover from that person an amount equal to that amount We paid. However, We will reimburse the Covered Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

We may exercise Our right to subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relived of liability by contract or operation of law. If We are precluded from exercising Our right of subrogation, We may exercise our right to reimbursement.

We, in exercising Our right of subrogation, will not seek to recover more than We paid under the Policy. We, in exercising our right of reimbursement, will not see to recover more than the amount recovered from a responsible third party.

**EXCESS PROVISION** No benefit under this Policy is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance. However, Injury due to a motor vehicle Accident is limited to [\$5000, \$10,000, \$15000, \$20,000] per Accident.

**ASSIGNMENT** At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefit may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

**CERTIFICATES OF INSURANCE** Where required by law, a certificate of insurance will be delivered to the Policyholder for delivery to each Covered Person. The certificate will list the benefits, conditions and limits of the Policy and will state to whom benefits will be paid.

**CONFORMITY WITH STATE STATUES** Any provision of this Policy which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

**BLANKET STUDENT ACCIDENT & SICKNESS POLICY**



Pan-American Life Insurance Company  
(hereinafter "Company")  
[601 Poydras Street  
New Orleans, Louisiana 70130]

**POLICYHOLDER:** [xxxxxxxxxx]  
**POLICY NUMBER:** [xxxxxxxxxx]  
**POLICY EFFECTIVE DATE:** [Date]  
**POLICY TERM:** [Date through Date]  
**STATE OF DELIVERY:** [State]

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:00 A.M., on the last day of the Policy Term unless the Policyholder and We agree to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the Premium Due Date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the state in which it is delivered.

Signed for PAN-AMERICAN LIFE INSURANCE COMPANY at New Orleans, Louisiana

A handwritten signature in black ink, appearing to read "David S. Sargent".

President and Chief Executive Officer

**[NOTICE REGARDING GUARANTEED AVAILABILITY OF BASIC AND STANDARD PLANS FOR BENEFITS TO ELIGIBLE PERSONS:** As described under the Health Insurance Portability And Accountability Act of 1996, eligible persons with health problems may find it more advantageous to choose a basic or standard plan of benefits from an insured that offers such plans in lieu of this blanket student accident and sickness policy. ]

**THIS IS A LEGAL CONTRACT  
PLEASE READ THE POLICY CAREFULLY  
NON-PARTICIPATING**

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## SCHEDULE OF ELIGIBLE CLASSES

A person may be insured under only one eligible class as set forth herein though he or she may be eligible under more than one class. Also, a person may not be insured as a Dependent and an Insured at the same time.

**[Class 1:** All full-time [and part-time] Domestic Students enrolled in and engaged in educational activities at Policyholder who cannot provide proof of an equal or better insurance plan will automatically be billed for coverage in the student health insurance plan.

**Class 2:** All full-time [and part-time] International Students or other persons possessing and maintaining a current passport and valid visa status (F-1, J-1 or M-1 etc.) engaged in educational activities at Policyholder who are temporarily located outside their Home Country and have not been granted permanent residency status are required to be insured under this Policy.

**Class 3:** All full-time [and part-time] Domestic [and International Students] enrolled in Policyholder while traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

**Class 4:** Dependents of Insureds as defined in the Definition Section of this Policy.]

[To be a Covered Person under this Policy, the person must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the Policyholder to Us. All Insureds must actively attend classes for the first 45 consecutive days following their effective date for the term purchased and/or pursuant to their visa requirements for the period for which coverage is purchased except in the case of medical withdrawal or during school authorized breaks. ]

We maintain Our right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that the Policy eligibility requirements have not been met, Our only obligation is a pro-rata refund of premium.

## SCHEDULE OF BENEFITS

Unless otherwise specified, Benefit Maximums apply on a per Covered Person, per Covered Accident/Covered Sickness basis.

Total Benefit Maximum for all Covered Expenses per covered Accident/Sickness: [\$50,000, \$100,000, \$250,000, \$500,000 or \$1,000,000]

Preferred Provider Deductible: [\$50, \$100, \$250, \$500, \$1,000] per Covered Person

Out-of-Network Deductible: [\$50, \$100, \$250, \$500, \$750, \$1,000] per Covered Person

[The Deductible is waived for the following Benefits:

]

### COVERAGE

### BENEFIT AMOUNT

#### HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum:

Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum

Miscellaneous Hospital Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[50%, 60%, 70%] of Reasonable Customary

Benefit Maximum:

Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum

#### SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Inpatient Surgery Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum:

Semi-private room rate up to [\$250, \$500, \$1,000] per day with 30 day maximum

Outpatient Surgery Expense Covered Percentage

Preferred Provider:

[80%, 90%, 100%] of Preferred Allowance

Out-of-Network:

[50%, 60%, 70%] of Reasonable & Customary

Multiple Surgical Procedure Expense Covered Percentage: Paid according to Policy language

Anesthesia Expense Covered Percentage:

[10%, 20%, 25%] of the paid Surgical Expense

Assistant Surgeon Expense Covered Percentage: [10%, 20%, 25%] of the paid Surgical Expense

**IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$250, \$500, \$1,000] per day with 30 day maximum

**OUTPATIENT EXPENSE BENEFIT**

Doctor's Office Visit Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Co-payment: [\$10, \$15, \$20, \$25] for Preferred Provider;  
[\$15, \$20, \$25, \$30] for Out-of Network provider

Chiropractic Care Office Visit Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$250, \$500, \$1,000, \$2,000] per Policy Year

Emergency Room Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%, 80%] of Reasonable & Customary for a Medical Emergency and [50%, 60%, 70%] of Reasonable & Customary for all other

Co-payment: [\$25, \$35, \$45, \$50, \$75, \$100, \$150] [(waived if admitted)]

Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Co-payment: [\$15, \$20, \$25] per condition  
Benefit Maximum: [\$500, \$750, \$1,000] per condition

[Physical Therapy Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance

Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$40, \$50, \$60, \$70] per visit, one visit per day with a 10 visit maximum]

[Speech Therapy Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

[Acupuncture Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

Benefit Maximum: [\$500, \$750, \$1,000] per Policy Year]

[Shots & Injections in a Doctor's Office Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

**MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum [\$10,000, \$25,000] per Policy Year

Outpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$40, \$50, \$60, \$70] per visit with a [\$500, \$1000, \$1500] per condition, per Policy Year

**SERIOUS MENTAL ILLNESS EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Outpatient Expense Covered Percentage:  
Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**ALCOHOL & DRUG ABUSE EXPENSE BENEFIT**

Inpatient Expense Covered Percentage:

Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$5,000, \$10,000, \$15,000, \$25,000] per Policy Year

Outpatient Expense Covered Percentage:

Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$2,500, \$5,000 \$10,000] per Policy Year

Benefit maximum for the treatment for withdrawal from the psychological effects of alcohol or drugs:

[\$1,500, \$2,500, \$5,000] per Policy Year

**[MATERNITY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**RECONSTRUCTIVE BREAST SURGERY EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[ACCIDENTAL DEATH & DISMEMBERMENT**

Principal Sum: [\$2,500, \$5,000, \$10,000, \$25,000 or \$50,000] [(Insured only)] ]

**[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT**

Covered Percentage Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$200 per tooth or \$500, \$750, \$1,000] [\$2000] per Policy year]

**[AMBULANCE EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$500, \$750, \$1,000] per Policy Year]

**[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$1000, \$2,500, \$5,000] per Policy Year]

**[HOME HEALTH CARE EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [50, 75, 100] visits per calendar year]

**[LICENSED NURSE EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[HOSPICE EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[PRE-ADMISSION TESTS EXPENSE BENEFIT]**

Covered Percentage: Paid under Hospital Miscellaneous]

**[PRESCRIPTION DRUG EXPENSE BENEFIT]**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Co-payment: Brand Name Drugs: [\$10, \$20, \$25, \$30] per prescription  
Generic Name Drugs: [\$5, \$10, \$15, \$20] per prescription

Benefit Maximum: [\$250, \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$5,000] per Policy Year]

**[CLINICAL TRIAL OR STUDY EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

**[INHERITED METABOLIC DISEASE EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary

Benefit Maximum: [\$2,500, \$5,000, \$7,500] per Policy Year for Special Food Products]

**[DIABETES SELF MANAGEMENT PROGRAM EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary]

**[COLORECTAL CANCER SCREENING EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider: [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[WELL BABY EXAMINATIONS AND CHILDHOOD IMMUIZATIONS EXPENSE BENEFIT]**

Covered Percentage: Preferred Provider [80%, 90%, 100%] of Preferred Allowance  
Out-of-Network: [50%, 60%, 70%] of Reasonable & Customary ]

**[HOME COUNTRY EXTENSION BENEFIT]**

Period of Coverage [30, 60 Days] ]

**[REPATRIATION OF REMAINS BENEFIT]**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Benefit Maximum: [\$5,000, \$10,000, \$15,000, \$20,000, \$25,000] ]

**[EMERGENCY MEDICAL EVACUATION BENEFIT]**

Covered Percentage: [80%, 90%, 100%] of Reasonable & Customary

Benefit Maximum: [\$10,000, \$25,000, \$50,000]]

**[INTERCOLLEGIATE SPORTS COVERAGE]**

Maximum per Injury: [\$1,500 ]  
Maximum per Tooth: [\$150] ]

**[SCHEDULE OF PREMIUM RATES**

	[From Date to Date]
[Student	[\$0000.00]
Spouse	[\$0000.00]
Child(ren)	[\$0000.00]]

Premiums received by Us are fully earned upon receipt. In addition to the eligibility requirement specified in the Eligibility for Insurance provision, refund of premiums will be considered only: 1) for Insureds withdrawing from a Study Abroad Program entirely before the departure date; or 2) for a Covered Person entering the Armed Forces of any country. Such person will not be covered under the Policy as of the date of his or her entry into to Armed Forces. A refund of unused premium will be made for such person with 90 days of withdrawal from the Policyholder when written notice is received by Us. No other refunds will be made. ]

## DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**“Accident”** means a sudden, unexpected and unintended event.

**“Covered Accident”** means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

**“Coinsurance”** means the percentage of Reasonable and Customary Charges for which the Covered Person is responsible for a covered service.

**“Complications of Pregnancy”** means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion).

**“Co-payment”** means the specified dollar amount a Covered Person must pay for specific charges. The co-payment is separate from and not a part of the Deductible or Coinsurance.

**“Covered Allowance”** means that part of the Covered Expenses that is payable by the Company after the Deductible or Co-payment has been met.

**“Covered Expenses”** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply was rendered or obtained.

**“Covered Loss” or “Covered Losses”** means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy.

**“Covered Percentage”** means that part of the Covered Expenses that is payable by the Company after the Deductible or Co-payment has been met.

**“Covered Person”** means any Insured [and Dependent] who enrolls for coverage and for whom the required premium is paid.

**“Deductible”** means the amount of Covered Expenses for Covered Expenses and supplies which must be incurred by the Covered Person before specified benefits become payable.

**["Dependent"]** means (a) the Insured's spouse residing with the Insured; [the Insured's Domestic Partner;] or (b) the Insured's unmarried children under the age of nineteen (19) years [or through the age of 25 if they are full-time students at an accredited school]. Children must be fully supported by the Insured. Coverage for newborn children will consist of coverage for Sickness or Accident including necessary care or treatment of congenital defects, birth abnormalities, premature birth and routine nursery care. Such coverage will start from the moment of birth if the Insured is already insured for dependent coverage when the child is born. If the Insured does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth or any minor child placed with an Insured for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured for adoption. To continue the newborn child's dependent benefits past the first 31 days, the Insured must notify Us in writing within 31 days of the child's birth.

The term "children" includes an Insured's biological children, step-children, adopted children from the date of placement in the Insured's home and who depend on the Insured for their full support.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of a physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured must send proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age. ]

**"Doctor"** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a Covered Person's Immediate Family Member or household.

**["Domestic Partner"]** means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Covered Person has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

**["Domestic Partnership"]** means a relationship between the Covered Person and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

- (a) [They share the same permanent residence and the common necessities of life;
- (b) They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- (c) Each is at least 18 years of age;
- (d) Each is mentally competent to consent to contract;
- (e) Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
- (f) They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - (1) have a single dedicated relationship of at least 6 months duration;
  - (2) joint ownership of residence;
  - (3) at least two of the following:
    - (i) joint ownership of an automobile;
    - (ii) joint checking, bank or investment account;
    - (iii) joint credit account;
    - (iv) lease for a residence identifying both partners as tenants;
    - (v) a will and/or life insurance policies which designates the other as primary beneficiary.

(g) The Covered Person and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

**“Domestic Student”** is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

**“Effective Date”** means the first date a student becomes covered under the Policy.

**“Elective Treatment”** means medical treatment which is not necessitated by a pathological change in the function or structure of any part of the body occurring after a Covered Person’s coverage goes into effect.

Elective Treatment includes, but is not limited to: tubal ligation, vasectomy, breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine examinations.

**“Experimental or Investigational Care”** means a service or supply:

- (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
- (b) which requires approval by any government authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

**“Home Country”** means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country which the Covered Person has declared to Us in writing as his or her Home Country.

**“Hospital”** means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place solely for the aged.

**“Hospital Confined”** means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

**“Immediate Family Member”** means a person who is related to the Covered Person in any of following ways: spouse; parent (includes stepparent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son- or daughter-in-law; and brother- or sister-in-law.

**“International Student”** is a student classified as a Non-Immigrant. For example, students holding visa types: “F” (Student), “J” (Exchange Visitor), “B” (Tourist) or “A” (Diplomat).

**“Injury”** means accidental bodily harm sustained by a Covered Person from a Covered Accident that results directly and independently from all other causes. [The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. ]

**“Insured”** means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. [An Insured is not a Dependent covered under the Policy. ]

**“Medical Emergency”** means the unexpected onset of an Injury or Sickness that requires immediate or urgent medical attention to avoid death or serious permanent damage to the body, or pain sufficient to warrant immediate care. It does not include elective or routine care.

**“Medically Necessary”** means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Covered Person or provider;
- (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Doctor may prescribe, order, recommend or approve a service or supply does not, itself, make the service or supply Medically Necessary.

**“Out-of Network Providers”** have not agreed to any pre-arranged fee schedules.

**“Policy Effective Date”** means the date the Policy takes effect as indicated on the face page of this Policy.

**“Policy Termination Date”** means the date the Policy ends, as indicated on the face page of this Policy.

**“Policy Year”** means the 12 month period beginning on the Policy Effective Date.

**“Preferred Allowance”** means the amount a Preferred Provider will accept as payment in full for Covered Expenses.

**“Preferred Providers”** are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

**“Reasonable and Customary Charge”** means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

**“Sickness”** [means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness].

**“Trip”** means travel by air, land or sea from the Covered Person’s Home Country.

**“We”, “Our”, “Us”** means the insurance company underwriting this insurance.

**“You” and “Your”** mean the Policyholder.

## **ELIGIBILITY FOR INSURANCE**

Each person within one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any unused premium paid for that person.

In no event will a dependent be eligible if the Insured is not eligible.

### **EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL**

This Policy takes effect as of the Policy Effective Date as indicated on the face page of this Policy. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided herein, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on any anniversary date of the Policy Effective Date. We will give the Policyholder at least sixty (60) days prior written notice. We also reserved the right to refuse to renew this Policy.

However, in no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.

### **EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE**

Insurance under the Policy will become effective at 12:01 a.m. on the latest of:

1. the Policy Effective Date;
2. the beginning date of the term for which premium has been paid;
3. the day after and enrollment form (if applicable) and premium payment are received by Us, the Policyholder or the plan administrator;
4. the day after the date of postmark if the enrollment form is mailed;
5. For international students and scholars, the date the Cover Person departs his or her Home Country to travel to the country of assignment provided that the scheduled arrival in the country of assignment is no more than 48 hours later than the departure from the Home Country (except for school authorized breaks).

[Coverage for Dependents will become effective at 12:01 a.m. on the latest of:

1. the Policy Effective Date;
2. the beginning date of the term for which premium has been paid; or
3. the day after the date the required individual enrollment form and premium payment are received by Us, the Policyholder or the plan administrator when premium payment is made within 31 days of the student's enrollment in the Policyholder's insurance plan. ]

### **[LATE ENROLLMENT FOR DEPENDENTS**

An Insured may add his or her Dependent as a late enrollee:

1. when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester or pro-rated premium is required even if the spouse is enrolled after the term has begun;
2. when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application for coverage must be submitted within 31 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun; and

3. when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun.

If the Insured does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage. ]

### **TERMINATION DATE OF INSURANCE**

An Insured's coverage will end on the earlier of the date:

1. the Policy terminates;
2. the Insured is no longer eligible;
3. the period ends for which premium is paid;
4. the date the Insured enters military service in which case a pro-rata refund of premium will be made to the Insured;
5. the Insured leaves the Policyholder, and cancels his or her coverage;
6. the last day the Insured is required to be on campus at the Policyholder and/or returns to his or her Home Country, except for Insureds traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder.

Termination of Insurance for an Insured shall be without prejudice to any claim which starts prior thereto.

[A Dependent's coverage will end on the earliest of the date:

1. the or she is no longer a Dependent;
2. the Insured's coverage ends;
3. the period ends for which premium is paid;
4. the last day the Insured is required to be on campus at the Policyholder and/or returns to his or her Home Country, except for Insureds traveling outside of their Home Country for up to 365 days to engage in education or cultural activities sponsored by the Policyholder. ]

### Certificates of Creditable Coverage

We will provide written certification of coverage to the Insured which certifies the length of:

1. The period of credible coverage that the person accumulated under the plan and any coverage under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 as that act existed on July 16, 1997, relating to the continuation of coverage; and
2. Any waiting and affiliation period imposed on the Insured pursuant to that coverage.

The certification of coverage will be provided to the Insured who was insured:

1. At the time he or she ceases to be covered under the plan if he or she does not otherwise become covered under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, as that act existed on July 16, 1997, relating to the continuation of coverage;
2. If he or she becomes covered under such a provision at the time that he or she ceases to be covered by that provision; and
3. Upon request, if the request is made not later than 24 months after the date on which he or she ceased to be covered as described in paragraphs (1) and (2) above.

## EXTENSION OF BENEFITS

We will extend benefits under the Policy for [30, 60, 90] days after a Covered Person's coverage would otherwise end if on that date he or she is:

1. Hospital Confined for an Injury or Sickness covered by the Policy; and
2. under a Doctor's care.

Any Benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits.

## [RENEWABILITY OF COVERAGE

A student who is enrolled as a regular undergraduate or graduate student at the Policyholder will be provided with continuous coverage under this Policy for himself or herself and his or her Dependents each subsequent year the Policyholder renews this Policy with Us. Once an Insured has been covered under this Policy and satisfied any Pre-existing Condition Limitation exclusion period, if applicable, coverage under this Policy will be considered continuous. The student must apply for coverage and pay premiums as described in the Policy. ]

## PRE-EXISTING CONDITION

**"Pre-existing Condition"** means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the [6 -12] months immediately preceding the Effective Date of the Insured's coverage under this Policy. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

The **"Pre-existing Condition Waiting Period"** is [6 - 12] months. If an Insured receives treatment or service for a Pre-Existing Condition: (a) We will not pay benefits for such condition until the day after a [6 – 12] consecutive month period has passed from the Insured's effective date; and (b) We will pay only for Covered Expenses incurred after such [6 – 12] consecutive month period.

The Pre-existing Condition Waiting Period will be reduced by the aggregate period of credible coverage of the Insured if the Credible Coverage was continuous to a date not more than 63 days before the Effective Date of coverage.

Payment will be in accord with the provisions of this Policy. If the Insured has a lapse in coverage for more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

The Pre-existing Condition Waiting Period will not apply:

1. [To pregnancy];
2. In the case of an Insured who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage;
3. In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.
4. In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured held Creditable Coverage and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

The provisions of paragraphs (2) and (3) do not apply to an Insured after the end of the first 63-day period during all of which the Insured was not covered under any Creditable Coverage.

**“Creditable Coverage”** means health benefits or coverage provided to a person pursuant to:

1. A group health plan;
2. A health benefit plan;
3. Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395c et seq., also known as Medicare;
4. Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec. 1396s;
5. The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefit risk pool;
8. A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seq.;
9. A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
10. A health benefit plan under Sec. 5(e) of the Peace Corps Act, U.S.C. Sec. 2504(e);
11. The children’s health insurance program established pursuant to 42 U.S.C. Sec. 1397aa to 1397jj, inclusive;
12. Organized delivery systems licensed by the director of public health;
13. A short-term health insurance policy; or
14. A blanket accident and health insurance policy.

## MANAGED CARE PROVISIONS

This Policy provides benefits based on the type of health care provider the Insured or his or her Dependents selects. This Policy provides access to both Preferred Providers and worldwide coverage for Out-of-Network Providers.

This Policy will pay the Covered Percentage of the Preferred Allowance for Covered Expenses if the Insured [or his or her Dependents] uses a Preferred Provider. This Policy will pay the Covered Percentage of the Reasonable and Customary Charge for Covered Expenses if an Out-of-Network Provider is used. All payments will be subject to any applicable Deductible, Co-insurance, Maximum Benefits and other provisions or limitation in this Policy. Covered Expenses are payable in accordance with the Schedule of Benefits.

Use of Preferred Providers offers better benefits for the Insured. Out-of-Network Provider services are subject to the Deductible and higher Co-insurance. Refer to the Schedule of Benefits for a complete description of coverage.

The Insured should be aware that Preferred Provider Hospitals may be staffed with Out-of-Network Providers. It is important that the Insured verify that his or her Doctors are Preferred Providers each time he or she calls for an appointment or at the time of service.

In the event a Covered Person is receiving medical treatment from a Preferred Provider and the Preferred Provider's contract is terminated during the course of medical treatment, then:

1. The Covered Person may continue to obtain medical treatment for the medical condition from the medical provider under the Preferred Provider contract if:
  - a. the Covered Person is actively undergoing a medically necessary course of treatment; and
  - b. the medical provider and the Covered Person agree that continuity of care is desirable.
2. The medical provider is entitled to receive reimbursement for the medical treatment if the medical provider agrees to:
  - a. to provide medical treatment to the Covered Person under the same terms, including, without limitation, the rates of payment, that existed before the termination of the Preferred Provider contract; and
  - b. not to seek payment from the Covered Person for any medical service provided by the medical provider that the medical provider could not have received if the medical provider were still under the Preferred Provider contract.
3. Coverage required by this section must be provided until the later of:
  - a. the 120<sup>th</sup> days after the date the Preferred Provider contract is terminated; or
  - b. if the medical condition is pregnancy, the 45<sup>th</sup> day after:
    - i. the date of delivery; or
    - ii. if the pregnancy does not end in delivery, the date of the end of the pregnancy.
4. The requirements in this section do not apply if:
  - a. The Preferred Provider contract was terminated due to the medical incompetence or professional misconduct of the medical provider; and
  - b. No new Preferred Provider contract was entered into with the medical provider.

### Deductible, Coinsurance and Co-payment Rules

**Deductible:** The Insured's Deductible applies to all Preferred Provider and Out-of-Network Provider Covered Expenses unless specified otherwise in this Policy.

**Coinsurance/Co-payments:** Some covered services are subject to Coinsurance and Co-payments. This is the amount the Insured must pay to the Doctor or Hospital for each procedure, visit or confinement each time he or she receives a covered service including prescription drugs. The Coinsurance is not applied until after the Insured has paid any applicable Deductible that may be required under this Policy. What We pay is shown in the Schedule of Benefits.

**Waiver of Co-payment:** The Emergency Room Co-payment will be waived if the Insured is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured received Medical Emergency care.

Certain medical procedures or treatments will require a prior notification request form to be received by the Company or the Company's authorized representative a minimum of 5 business days prior to the scheduled procedure date and approval must be received prior to the commencement of the proposed medical treatment. Prior notification is also required for any procedure or treatment that the Covered Person's Doctor anticipates will exceed \$1,000.

Services requiring prior authorization are:

1. All Inpatient admissions and/or treatments;
2. Any surgeries requiring general anesthesia (Outpatient or Inpatient)
3. [Accidental Dental treatment (for emergency dental repair of natural sound teeth damaged in an accident;]
4. [Purchase or rental of Durable Medical Equipment;]
5. [Home Health Care;]
6. [RSV Immunization and other medications priced in excess of \$1,000 per refill;]
7. All cancer treatments/therapies;
8. Hemodialysis and Peritoneal Dialysis for renal failure;
9. Substance Abuse treatments/therapies;
10. Any condition, including chronic conditions that do not meet the above criteria, but are expected to accumulate over \$1,000 in Covered Expenses per Policy Year.

## DESCRIPTION OF BENEFITS

The following Provisions explain the benefits available under the Policy.

### **ACCIDENT EXPENSE BENEFIT**

When, by reason of Injury, a Covered Person incurs expenses for hospital, surgical or medical treatment, services or supplies including while traveling outside their Home Country for [up to 365 days] to engage in educational or cultural activities sponsored by the Policyholder, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

[Covered Expenses must be incurred within [52 weeks] after the date of the Accident.]

What We pay is shown in the Schedule of Benefits.

### **SICKNESS EXPENSE BENEFIT**

When, by reason of Sickness, a Covered Person incurs expenses for hospital, surgical or medical treatment, services or supplies including while traveling outside their Home Country for [up to 365 days] to engage in educational or cultural activities sponsored by the Policyholder, We will pay for the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

[Covered Expenses must be incurred within [52 weeks] after the date of the Sickness. ]

What We pay is shown in the Schedule of Benefits.

### **HOSPITAL EXPENSE BENEFIT**

#### **Part A: Hospital Room and Board Expense**

When, by reason of Injury or Sickness, a Covered Person is required to be Hospital Confined, We will pay the Covered Percentage of the Hospital room and board Covered Expense for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a newborn nursery, special care or intensive care unit.

#### **Part B: Miscellaneous Hospital Expense**

“Miscellaneous Hospital Expense” includes expenses incurred for:

1. anesthesia, anesthesia supplies and services;
2. operating, delivery and treatment rooms and equipment;
3. diagnostic x-ray and laboratory tests;
4. lab studies;
5. oxygen tent;
6. blood and blood services;
7. prescribed drugs and medicines;
8. medical and surgical dressings, supplies, casts and splints;
9. radiation therapy, intravenous chemotherapy, kidney dialysis and inhalation therapy;
10. chemotherapy treatment with radioactive substances;
11. intravenous injections and solutions and their administration;
12. physical therapy; and
13. other necessary and prescribed Hospital expenses.

We will pay the Coverage Percentage of the Covered Expenses incurred by the Covered Person during the period of Hospital Confinement for a Surgical procedure performed on an outpatient basis. What We pay is shown in the Schedule of Benefits.

## **SURGICAL EXPENSE BENEFIT**

### **Part A: Surgery Expense Benefit**

When, by reason of Injury or Sickness, a Covered Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Expenses of the Surgical Expense in connection with any one Surgical Procedure. What We pay is shown in the Schedule of Benefits.

#### **Definitions:**

**“Surgical Expense”** means charges by a Doctor for:

1. a Surgical Procedure;
2. necessary preoperative treatment during a Hospital stay in connection with such procedure; and
3. usual post-operative treatment.

**“Surgical Procedure”** means:

1. a cutting procedure;
2. suturing of a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. radiotherapy;
6. electrocauterization;
7. diagnostic and therapeutic endoscopic procedures;
8. injection treatment for hemorrhoids and varicose veins;
9. an operation by means of a laser beam.

### **Part B: Multiple Surgical Procedures Expense Benefit**

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Expense of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to fifty percent (50%) of the Covered Percentage of the Covered Expense for these procedures.

### **Part C: Anesthesia Expense Benefit**

If, in connection with such operation, the Covered Person requires the services of an anesthetist, We will pay the expense incurred, but We will not pay more than the Covered Percentage of Covered Expenses. What We pay is shown in the Schedule of Benefits.

### **Part D: Assistant Surgeon Expense Benefit**

If, in connection with such operation, the Covered Person requires the services of an Assistant Surgeon, We will pay the expense incurred, but We will not pay more than the Covered Percentage of the Covered Expenses. What We pay is shown in the Schedule of Benefits.

## **IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Covered Person, We will pay the Covered Percentage of the Covered Charges incurred for such services.

The following medical services performed by a Doctor are covered on an inpatient basis:

1. one Doctor visit per day;
2. constant care and treatment while a Covered Person is confined in an intensive care unit;
3. care by two or more Doctors during one Hospital stay when the Covered Person's condition requires the skill of separate Doctors;

4. consultation by another Doctor when request by the Covered Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.

What we Pay is shown in the Schedule of Benefits.

### **OUTPATIENT EXPENSE BENEFIT**

If, by reason of Injury or Sickness, a Covered Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility or other similar facility licensed by the state, We will pay the Covered Percentage of Covered Expenses incurred as shown in the Schedule of Benefits. What We pay is shown in the Schedule of Benefits.

#### **Outpatient Services**

Covered Expenses for "**Outpatient Services**" include the following services:

1. a Doctor's office while not Hospital Confined ;
2. [chiropractic care up to the maximum shown in the Schedule of Benefits;]
3. a Hospital outpatient department or emergency room;
4. diagnostic x-ray and laboratory testing;
5. blood and blood services if provided and billed by a Hospital or other facility;
6. [physical therapy as shown in the Schedule of Benefits;]
7. radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;
8. radiological lab or other similar facility licensed by the state;
9. surgical dressings, splints, casts and other devices used to correct fractures and dislocations;
10. [speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment after corrective surgery or following an Injury or Sickness other than a mental or learning disorder. Speech therapy must be in keeping with a Doctor's written order for type, frequency and duration;]
11. [shots or injections when received in the Doctor's office;]
12. [acupuncture up to the maximum shown in the Schedule of Benefits.]

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

With regard to a Doctor's office visit for gynecological or obstetrical services, a women is not required to first receive authorization or a referral from her primary care physician.

### **MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT**

If a Covered Person requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

#### **Benefits for Inpatient Hospital Confinement**

When a Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Covered Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility, including Hospitals. What We pay is shown in the Schedule of Benefits.

#### **Benefits for Outpatient Services**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of Mental and Nervous Conditions.

The Mental and Nervous Condition must, in the professional judgment of health care providers, be treatable and the treatment must be Medically Necessary.

Outpatient Treatment and Doctor services include charges made by an outpatient treatment department of a Hospital, community mental health facility if approved by the joint commission on accreditation of healthcare organizations or charges for services rendered in a Doctor's office. Treatment may be provided by any properly licensed Doctor, psychologist, a professional clinical counselor, professional counselor, independent social worker, clinical nurse specialist with a specialty in mental health, marriage and family therapist or other provider as required by law. What We pay is shown in the Schedule of Benefits.

**Definition**

**"Mental or Nervous Condition"** means those conditions listed in the standard nomenclature of the American Psychiatric Association.

**SERIOUS MENTAL ILLNESS EXPENSE BENEFIT**

When a Covered Person requires Hospital Confinement or outpatient services for the treatment of a Serious Mental Illness, We will pay the Covered Percentage of the Covered Expenses incurred on the same basis as any other Sickness.

Benefits are available for 30 days of Inpatient hospitalization and 60 days of outpatient medical treatment per Policy Year, excluding visits for the management of medications and that 2 visits for partial or respite care, or a combination thereof, may be substituted for each 1 day of hospitalization not used by the Covered Person.

**Definitions:**

**"Serious Mental Illness"** means any of the following biologically based mental illnesses:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Bipolar disorder;
4. Major Depressive disorder;
5. Paranoia and other psychotic disorders;
6. Panic disorder;
7. Obsessive-compulsive disorder;
8. Anorexia Nervosa;
9. Bulimia Nervosa; and
10. Delusional Disorder

**ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT**

If a Covered Person requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

**Benefits for Inpatient Confinement**

When the Covered Person is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Covered Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit.

Such confinement must be in a licensed or certified facility by the Health Division of the Department of Health and Human Services.

What We pay is shown in the Schedule of Benefits.

### **Benefits for Outpatient Services**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency.

Outpatient Treatment and Doctor services include charges for services rendered in a Doctor's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility so long as the Hospital, community mental health facility, or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Doctor or a licensed psychologist who certifies every three months that the Covered Person needs to continue such treatment.

What We pay is shown in the Schedule of Benefits.

### **Definitions**

**"Alcohol Abuse"** means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

**"Drug Abuse"** means a condition which is characterized by a pattern of pathological use of a drug with repeated attempts to control its use and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

**"Detoxification Facility"** means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

1. monitoring the amount of alcohol and other toxic agents in the body of the individual;
2. managing withdrawal symptoms; and
3. motivating the individual to participate in the appropriate addiction treatment programs for Alcohol or Drug Abuse.

### **[MATERNITY EXPENSE BENEFIT**

We will pay benefits for a Covered Person's Covered Expenses for maternity care including routine tests, screening exams and Complications of Pregnancy for Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility unless the attending Doctor in consultation with the mother makes a decision for an earlier discharge from the Hospital.

For a mother and newborn child who remain in the Hospital for a minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for one home visit scheduled within 24 hours after Hospital discharge and an additional home visit if prescribed by an attending provider.

[Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.]

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

We cover such charges the same way We treat Covered Expenses for any other Sickness.

What We pay is shown in the Schedule of Benefits.]

#### **MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for mammographic exams. The charges must be incurred while the Covered Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

1. Any Mammogram based upon a Doctor's recommendation for women under 40 years of age; and
2. One Mammogram every twelve months for a woman 40 years of age or older or more frequently upon recommendation of a Doctor;

We cover such charges the same way We treat Covered Expenses for any other Sickness. A women is not required to first receive authorization or a referral from her primary care physician.

What We pay is shown in the Schedule of Benefits.

#### **Definition**

**"Mammogram"** means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression devise, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

#### **RECONSTRUCTIVE BREAST SURGERY EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for Reconstructive Breast Surgery the same as any other Sickness for a Covered Person's reconstructive surgery incident to a covered mastectomy. Benefits shall include reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment for any physical complications for all states of mastectomy including lymphedemas in a manner determined with the Doctor and the Covered Person.

If the reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the Policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all the terms, conditions and exclusions contained in the Policy at the time of the reconstructive surgery.

**"Reconstructive Surgery"** means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

#### **CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT**

We cover charges for Expenses incurred for an annual Cytologic Screening (Pap Smear) for women 18 years of age or older or more frequently when recommended by a Doctor, nurse practitioner or a certified nurse midwife. Such benefits will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.

We cover such charges the same way We treat Covered Expenses for any other Sickness. A women is not required to first receive authorization or a referral from her primary care physician.

What We pay is shown in the Schedule of Benefits.

**Definition**

“**Cytologic Screening**” means a pap test to detect cervical cancer through the simple microscope examination of cells scraped from the surface of the cervix.

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS [(Insured Only)]**

If Injury to the Covered Person results in any one of the losses shown below, We will pay the Benefit Amount shown below for that loss. [Loss must occur within [90 days] of the date of the accident which caused the loss.] The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Accident.

Covered Loss	Benefit Amount
Life .....	100% of the Principal Sum
Two or more Members.....	100% of the Principal Sum
One Member.....	50% of the Principal Sum

“**Member**” means Loss of Hand or Foot, and Loss of Sight. “**Loss of Hand or Foot**” means complete Severance through or above the wrist or ankle joint. “**Loss of Sight**” means the total, permanent Loss of Sight of one eye. “**Severance**” means the complete separation and dismemberment of the part from the body.]

**[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT**

We will pay the Covered Percentage of Covered Expenses incurred as a result of an accidental dental injury. What We pay is shown in the Schedule of Benefits.]

**[AMBULANCE EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

What We pay is shown on the Schedule of Benefits.]

**[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT**

If, by reason of Injury or Sickness, a Covered Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for such Durable Medical Equipment. We pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is Our property and is to be returned to Us, at Our expense, upon completion of the Covered Person’s need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

What We pay is shown in the Schedule of Benefits.

**Definition**

**“Durable Medical Equipment”** means medical equipment that: 1) is prescribed by the Doctor who documents the necessity for the item including the expected duration of its use; 2) can withstand long term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision. ]

**[HOME HEALTH CARE EXPENSE BENEFIT**

We will cover charges for Home Health Care services furnished to a Covered Person. Such benefits must be provided by a licensed Home Health Agency. Except for a home health aid, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aid shall be considered as one home health visit.

Charges for such services are not subject to the Deductible. What We pay is shown in the Schedule of Benefits.

**Definitions**

**“Home Health Care”** means the continued care and treatment of a Covered Person who is under the direct care and supervision of a Doctor but only if: (a) continued hospitalization would have been required if Home Health Care were not provided; (b) the home health treatment plan is established and approved by a Doctor within 14 days after an inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Covered Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

**“Home Health Services”** Consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Policy if the Covered Person had remained in the Hospital.

**“Home Health Agency”** means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Health and Safety Code.]

**[HOSPICE EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for Hospice Care. What We pay is shown in the Schedule of Benefits.]

**LICENSED NURSE EXPENSE BENEFIT**

If by reason of Injury or Sickness, a Covered Person requires the services of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Expenses incurred. What We pay is shown in the Schedule of Benefits.

**[PRE-ADMISSION TESTS EXPENSE BENEFIT**

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Expenses made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to a Covered Person’s admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Covered Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Covered Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Schedule of Benefits for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provided for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Covered Person only to the extent that the Covered Person is insured under this Policy for Hospital Expense Benefits. What We pay is shown in the Schedule of Benefits.]

#### **[PRESCRIPTION DRUG EXPENSE BENEFIT**

If by reason of Injury or Sickness, a Covered Person requires drugs, We will pay the Covered Percentage of the Covered Expenses incurred by the Covered Person for such drugs and the Medically Necessary services associated with the administration of such drugs subject to the Co-payment shown in the Schedule of Benefits.

The drugs must be prescribed by a Doctor. Coverage includes any type of drug or device for contraception and any type of hormone replacement therapy which is lawfully prescribed or ordered by a Doctor and which has been approved by the Food and Drug Administration.

We only cover drugs which are approved for the treatment of the Covered Person's Injury or Sickness by the Food and Drug Administration.

We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established referenced compendia:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopoeia Drug Information; or
4. it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

However, Covered Expenses do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Coverage for prescription drugs will not be limited or excluded if the drug:

1. had previously been approved for coverage for a Covered Person's medical condition and the Covered Person's medical provider determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved are medically appropriate for the Covered Person; and
2. is appropriately prescribed and considered safe and effective for treating the Covered Person's medical condition.
3. The provisions of 1 and 2 above do not:
  - a. apply to any drug that is prescribed for a use different from the use for which that drug has been approved for marketing by the Food and Drug Administration;
  - b. prohibit charging a Deductible, Co-payment or Coinsurance or from establishing maximum benefits covered under the Policy; or

- c. a medical provider from prescribing another drug that is medically appropriate for the Covered Person.

What We pay is shown in the Schedule of Benefits.]

**[CLINICAL TRIAL OR STUDY EXPENSE BENEFIT**

When, by reason of Injury or Sickness, a Covered Person receives medical treatment as part of a clinical trial or study, We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits if:

1. the medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;
2. the clinical trial or study is approved by:
  - a. an agency of the National Institutes of Health as set forth in 42 U.S.C. section 281(b);
  - b. a cooperative group;
  - c. the Food and Drug Administration as an application for a new investigational drug;
  - d. the United States Department of Veterans Affairs; or
  - e. the United States Department of Defense;
3. in case of:
  - a. a phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical studies for the treatment of cancer; or
  - b. A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a medical provider with qualified personnel having experience and training to provide the treatment in a capable manner.
4. There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;
5. There is no reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study is conducted in the Policyholder's state of domicile; and
6. The Covered Person has signed, before his participation in the clinical trial or study, a statement of consent indicating that he or she has been informed of, without limitation;
  - a. the procedure to be undertaken;
  - b. alternative methods of treatment; and
  - c. the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

Coverage for medical treatment under by this section is limited to:

1. coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the Covered Person.
2. reasonably necessary costs for health care services.
3. the initial consultation to determine if the Covered Person is eligible to participate in the clinical trial or study.
4. Health care services to monitor the Covered Person during the clinical trial or study.
5. Medical treatment provided by the sponsor of the clinical trial or study not free of charge to the Covered Person.

Coverage for medical treatment under this section does not include:

1. any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
2. coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device.

3. health care services that are specifically excluded by this Policy regardless of whether such services are provided under the clinical trial or study.
4. extraneous expenses including, without limitation, travel, housing and other expenses.
5. any expenses incurred by a person who accompanies the Covered Person during the clinical trial or study.

What We pay is shown in the Schedule of Benefits.]

#### **[INHERITED METABOLIC DISEASE EXPENSE BENEFIT**

We will pay the Covered Percentage of the Covered Expenses incurred for certain Inherited Metabolic Diseases. Benefits will include: 1) enteral formulas for use at home that are prescribed or ordered by a Doctor as Medically Necessary and characterized by deficient metabolism, or malabsorption originating from congenital defects or defect arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and 2) [\$2,500, \$5,000, \$7,500] per Policy Year for Special Food Products which are prescribed or ordered by a Doctor as Medically Necessary.

#### **Definition**

**“Inherited Metabolic Disease”** means a disease caused by an inherited abnormality of the body chemistry of a person.

**“Special Food Product”** means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the directions of a Doctor for the dietary treatment of an Inherited Metabolic Disease. The term does not include food that is naturally low in protein.]

#### **[DIABETES MANAGEMENT AND TREATMENT EXPENSE BENEFIT**

We cover charges for Covered Expenses relating to the management and treatment of diabetes, including, without limitation, coverage for the self-management of diabetes. Diabetes includes type I, type II and gestational diabetes.

We cover such charges the same way We treat Covered Expenses for any other Sickness. What We pay is shown in the Schedule of Benefits.

Coverage for the management and treatment of diabetes includes coverage for medication, equipment, supplies and appliances that are Medically Necessary for the treatment of diabetes.

Coverage for the self-management of diabetes includes:

1. the training and education provided to the Covered Person after he or she is initially diagnosed with diabetes which is Medically Necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
2. training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Covered Person and which requires modification of his or her diabetic self management program; and
3. training and education which is Medically Necessary because of the development of new techniques and treatment for diabetes. ]

#### **[COLORECTAL CANCER SCREENING**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for screening of Colonrectal Cancer.]

**[WELL BABY CARE AND IMMUNIZATION EXPENSE BENEFITS**

We will pay the Covered Percentage of the Covered Expenses incurred as shown in the Schedule of Benefits for Medically Necessary preventative medical services rendered to the Insured's child up to the age of 2 enrolled as a Dependent which include:

1. physical examinations;
2. immunizations;
3. history measurements;
4. sensory scanning;
5. neuropsychiatric evaluation and development;
6. screening and assessments.

The Deductible and Coinsurance requirements shown in the Schedule of Benefits are waived. What We pay is shown on the Schedule of Benefits.]

**[HOME COUNTRY EXTENSION BENEFITS**

We will pay benefits for Covered Expenses if the Covered Person obtains follow-up treatment of an Injury or Sickness while he or she is in his or her Home Country during the course of a Trip for which a benefit is otherwise payable under the Policy.

Benefits will be paid for a period of [30-60] days from the date the Covered Person returns to his or her Home Country. Home Country Extension Benefit payments are subject to the Benefit Maximums, Covered Percentage, Deductible and Co-payment shown in the Schedule of Benefits.]

**[REPATRIATION OF REMAINS BENEFIT**

We will pay Repatriation Benefits as shown in the Schedule of Benefits for preparation and return of a Covered Person's body to his or her Home Country if he or she dies due to an Injury or Sickness. Covered Expenses include, but are not limited to:

1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains by the most direct and least costly conveyance and route possible.

Benefits will not be payable unless We authorize all expenses in advance, in writing, or by an authorized electronic or telephonic means.]

**[EMERGENCY MEDICAL EVACUATION BENEFIT**

We will pay benefits for Covered Expenses as shown in the Schedule of Benefits for a Covered Person's Emergency Medical Evacuation.

Benefits are payable if the Covered Person:

1. is traveling outside his or her Home Country;
2. suffers an Injury or Sickness during the course of the Trip; and
3. requires Emergency Medical Evacuation.

Benefits will not be payable unless:

1. the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Injury or Sickness requiring the Emergency Medical Evacuation;
2. all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
3. the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
4. do not include charges that would not have been made if there were no insurance.

**Definitions**

**“Emergency Medical Evacuation”** means:

1. the immediate transportation from the place where the Covered Person suffers an Injury or Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or
2. transportation to your Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness.

An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation.]

**[INTERCOLLEGIATE SPORTS BENEFIT**

We will pay benefits for Covered Expenses as shown in the Schedule of Benefits if a Covered Person sustains an Injury while practicing, playing or traveling to or from an intercollegiate sports event as a member of a sports team or tryout squad are covered, up to the maximum amount shown in the Schedule of Benefits for each accident. Benefits for Injury to natural teeth will be limited to a per-tooth maximum amount.]

## COORDINATION OF BENEFITS

If a Covered Person is eligible for benefits under this policy and any other plan, We will pay benefits as explained in this provision.

### Definitions

**“Plan of Health Coverage”** means an individual or group insurance plan or an individual or group contract of a health insuring corporation providing hospital, dental, surgical or medical services or any other individual or group benefit plan or third-party payer plan providing hospital, dental, surgical or medical services. These coverages include: a) individual, group or blanket insurance coverage, or any other individual or group type contract or provision; b) service plan contracts, group practice and other pre-payment group coverage; c) any coverage under labor-management trustee plans, union welfare plans, employer and employee plans; and coverage under any government program, including Medicare, and any coverage required or provided by law. A primary plan pays benefits first. A secondary plan pays a reduced amount of benefits that when added to the benefits paid by the primary plan will not be more than the Allowable Expenses.

**“Allowable Expenses”** means any necessary, reasonable and customary item of expense, a part of which is covered by at least one of the Plans covering the Covered Person. During any Policy year or benefit period, the sum of the benefits that are payable by Us and those benefits that are payable from another Plan of Health Coverage may not be more than the Allowable Expenses. During any Policy year or benefit period, We may reduce the amount We pay so that this reduced amount plus the amount payable by the other Plan of Health Coverage will not be more than the Allowable Expenses.

Allowable Expenses under the other Plan of Health Coverage include benefits that would have been payable if a claim had been made.

However, if: 1) the other Plan of Health Coverage contains a section that provides for determining its benefits after Our benefits have been determined; and 2) the order of benefit determination stated in this Policy would require Us to determine benefits before the other Plan of Health Coverage, then the benefits of such other Plan of Health Coverage will be ignored in determining the benefits We will pay.

This Policy determines its order of benefits using the first of the following rules that applies:

1. If the other Plan of Health Coverage does not have a Coordination of Benefits, that Plan of Health Coverage pays first.
2. The benefits of the Plan of Health Coverage that covers the person as an employee, member, insured or subscriber are determined before those of the Plan of Health Coverage that covers the person as a Dependent.
3. If this Policy and another Plan of Health Coverage cover the same child as a Dependent of different parents who are not divorced or separated or divorced:
  - A. the benefits of the Plan of Health Coverage of the parent whose birthday falls earlier in the year (without regard to the year of birth) are paid before the benefits of the Plan of Health Coverage of the parent whose birthday falls later in the year;
  - B. if both parents have the same birthday, the benefits of the Plan of Health Coverage that covered the parent longer pays benefits before the benefits of the Plan of Health Coverage that covered the other parent for a shorter time.

However, if the Plans of Health Coverage do not agree on the order of benefits, the rule of the other Plan of Health Coverage will determine the order of benefits.

4. If two or more Plans of Health Coverage cover a person as a Dependent child of divorced or separated parents, benefits will be determined in this order:
  - A. first, the Plan of Health Coverage of the parent with custody of the child;
  - B. then, the Plan of Health Coverage of the spouse of the parent with custody of the child; and
  - C. finally, the Plan of Health Coverage of the parent not having custody of the child.
5. If none of the above rules determines the order of benefits, the benefits of the Plan of Health Coverage that covered an employee, member, insured or subscriber longer are determined before those of the Plan of Health Coverage that covered that person for the shorter time.

To determine how this provision should apply, We may without further consent or notice release to, or obtain from, any other insurance company or organization, any necessary information. Any person claiming benefits under the Policy shall give Us the information We need to implement this provision. We will give the Covered Person notice of this exchange of claim and benefit information when the claim is filed.

Whenever payments are made by another Plan of Health Coverage that should have been paid under the Policy, We shall pay any amount require to satisfy our share of the benefits paid. Any amounts paid in this way will be considered benefits paid under the Policy. Any payment made in good faith will end our liability to the extent of the payment.

If We pay benefits for Allowable Expenses that exceed our obligation under this provision, We may recover the excess payment. We may recover these excess payments from any person, for whom benefits were paid, or to any person or organization to which benefits were paid, or from any other insurer, service plan or other organization.

## EXCLUSIONS

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary or Hospital or by Health Care Providers employed by the Policyholder;]
2. [Preventative medicines, serums, immunizations or vaccines except as specifically provided;]
3. [Care and/or treatment in skilled nursing facility except as specifically provided;]
4. [Organ transplants;]
5. [Hospice services except as specifically provided;]
6. [Pre-existing Conditions as defined in this Policy;]
7. [Nonprescription drugs or medicines;]
8. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country except as specifically provided. Upon the Covered Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Covered Person;]
9. [Sickness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate clubs sports and professional sports[ except as specifically provided];]
10. [Injury resulting from motor vehicle accident in excess of [\$5,000, \$10,000, \$15,000, \$20,000] per Accident;]
11. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Covered Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]
12. [Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planning, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;]
13. [Correction of congenital defects except as specifically provided;]
14. [Injury of Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]
15. [Expense incurred as the result of dental treatment except as provided in the Accidental Dental Expense Benefit if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;]

16. [Expense incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision, when applicable;]
17. [Injury or Sickness resulting from declared or undeclared war or any act thereof;]
18. [Charges for treatment of any Injury or Sickness due to a Covered Person's commission of or attempt to commit a felony or a crime which would be considered a felony if prosecuted;]
19. [Injury due to participation in a riot;]
20. [Charges for which a Covered Person has no legal obligation to pay in absence of this or like coverage;]
21. [For services or supplies rendered by a close relative of the Covered Person. By "**close relative**" We mean a Covered Person's spouse, children, parents, brothers and sisters;]
22. [Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat fee; subluxation; corns, calluses; bunions except open cutting operations, routine care of toenails except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet and any tarsalgia or metatarsalgia. Expenses incurred for the care and treatment of Injury, infection or disease are not excluded;]
23. [Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination and services or supplies for inducing conception;]
24. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]
25. [Treatment for obesity including any care which is primarily dieting or exercise for weight loss except for surgical treatment of morbid obesity;]
26. [Expense incurred for eye examination or prescriptions, eyeglasses, contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, lasix or other vision procedures except as required for repair caused by a covered Injury;]
27. [Well baby care including routine exams and immunizations except as specifically provided;]
28. [Routine periodical physical examination and routine chest x-rays except as specifically provided;]
29. [Expenses incurred for allergy testing and allergy treatment;]
30. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]
31. [An amount of a charge in excess of the Reasonable and Customary Charge;]
32. [Elective Treatment or elective surgery except as specifically provided;]

33. [Services not Medically Necessary;]
34. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare paying passenger in an aircraft operating by a scheduled airline maintaining regular published schedules on a regularly established route;]
35. [Treatment of mental or nervous disorder except as specifically provided;]
36. [Treatment for alcohol and substance abuse except as specifically provided;]
37. [Suicide, attempted suicide or intentionally self-inflicted injury;]
38. [Expense incurred for: tubal ligation; vasectomy; breast implants, breast reduction, sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism and learning disabilities or disorders of Attention Deficit Disorder;]
39. [Voluntary or elective abortion; pregnancy of a dependent child;]
40. [Illegal drugs;]
41. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication, legend vitamins or food supplements, smoking deterrents, immunization agents, biological sera, drugs to promote or stimulate hair growth, experimental drugs, drugs dispensed in a rest home or hospital except as provided under the Hospital Expense Benefit;]
42. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication or for any drug which the FDA has determined to be contraindicated for a particular condition;]
43. [Testing, treatment or services for any condition in the absence of Sickness or Injury except as specifically provided;]
44. [Hearing aids, including exams for fitting except as required to correct damage caused by an Injury which occurs while the patient is covered by this Policy provided they are obtained within four months of the date of the Injury;]
45. [Expense for hair replacement, wigs or wig maintenance; or]
46. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy.]

## GENERAL PROVISIONS

**PREMIUMS** The premiums for the Policy will be based on the rates currently in force, the coverage and amount of insurance in effect.

**CHANGES IN PREMIUM RATES** We may change the premium rates from time to time with at least 60 days advanced written or authorized electronic or telephonic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. There is a misrepresentation in the information We relied on in establishing the rate.
5. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

**PAYMENT OF PREMIUM** The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

**POLICY GRACE PERIOD** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

**ENTIRE CONTRACT; CHANGES** The entire contract is made up of: (a) this Policy, including Your application; and (b) the individual applications, if any, of Covered Persons. Statements made by the Policyholder or a Covered Person, in the absence of fraud, shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person or to his/her beneficiary. The Insured, his beneficiary or assignee has the right to make a written request to the Company for a copy of the application and the Company shall, within 15 days after the receipt of a request at its home office or any authorized agent's office, deliver or mail to the person making the request a copy of the application. If a copy is not delivered or mailed, the Company is precluded from introducing the application as evidence in any action based upon or involving any statements contained therein.

No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidence by endorsement on this Policy signed by the Policyholder and Us. No agent has authority to change this Policy or to waive any of its provisions.

**CLERICAL ERROR** If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the terms and conditions of the Policy.

**NOTICE OF CLAIM** Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any Covered Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us or to any authorized agent with information sufficient to identify the Covered Person shall be deemed notice to Us.

**CLAIM FORMS** Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of loss by giving written proof of: (a) the occurrence of the Covered Loss; (b) the nature of the Covered Loss; and (c) the extent of the Covered Loss.

**PROOF OF LOSS** Written proof of loss must be given to Us or to any authorized agent within 90 days after the date of such Covered Loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

**TIME PAYMENT OF CLAIMS** Benefits payable under this Policy will be paid as they accrue and as soon as due written proof of such loss has been received by Us.

**PAYMENT OF CLAIMS** All benefits other than death will be paid to the Covered Person. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. We must receive the request no later than the time for filing proof of loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured.

Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's:

1. spouse;
2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); mother or father;
3. estate.

All other benefits due and not assigned will be paid to the Covered Person, if living.

Otherwise, the benefits may, at our option, be paid:

1. according to the beneficiary designation; or
2. to the Covered Person's estate.

If a benefit due is payable to:

1. the Covered Person's estate; or
2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment.

We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith.

The Covered Person may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Insured is the beneficiary for any covered Dependent.

**APPEALS PROCEDURE** If a claim is wholly or partially denied, a written notice will be sent to the Covered Person containing the reason for the denial. The notice will include a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal along with any additional information or comments may be sent within 6 months after notice of denial. In preparing the appeal, the Covered Person, or his/her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

**PHYSICAL EXAMINATION** At Our own expense, We have the right to have a Doctor examine a Covered Person when and so often as We deem reasonably necessary while there is a claim pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

In the event the Company, for final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any Covered Person, only a Doctor or chiropractor who is certified to practice in the same field of practice may conduct the independent evaluation. The independent evaluation must include a physical examination of the Covered Person and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of the findings must be sent to the primary treating physician or chiropractor and the Covered Person within 10 working days after the evaluation. If the Covered Person disagrees with the finding of the evaluation, he must submit an appeal to the Company pursuant to the procedure for binding arbitration set forth herein within 30 days after he receives the finding of the evaluation. The procedure for binding arbitration to resolve disputes concerning independent medical examinations shall follow the rules of the American Arbitration Association.

**LEGAL ACTIONS** No one may sue Us for payment of claim: (a) less than 60 days after due proof of claim is furnished; or (b) more than three years after the date proof of claim is required by this Policy.

**RECORDS MAINTAINED** You shall maintain records of each person insured. The records shall show all data that is needed to administer this Policy.

**REPORTING REQUIREMENT** The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. any additional information required by Us.

**EXAMINATION AND AUDIT** We shall be allowed to examine and audit Your books and records which pertain to this Policy at reasonable times. We may also be allowed to do this within 3 years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

**SUBROGATION AND RECOVERY RIGHTS** If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Covered Person will do whatever is necessary to enable Us to exercise Our right and will do nothing after to prejudice it. If We are precluded from exercising Our right to subrogation, We may exercise Our right to reimbursement.

If benefits are paid under this Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have the right to recover from that person an amount equal to that amount We paid. However, We will reimburse the Covered Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

We may exercise Our right to subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relived of liability by contract or operation of law. If We are precluded from exercising Our right of subrogation, We may exercise our right to reimbursement.

We, in exercising Our right of subrogation, will not seek to recover more than We paid under the Policy. We, in exercising our right of reimbursement, will not see to recover more than the amount recovered from a responsible third party.

**EXCESS PROVISION** No benefit under this Policy is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance. However, Injury due to a motor vehicle Accident is limited to [\$5000, \$10,000, \$15000, \$20,000] per Accident.

**ASSIGNMENT** At the request of the Covered Person or his or her parent or guardian, if the Covered Person is a minor, medical benefit may be paid to the provider of service. Any payment made in good faith will end our liability to the extent of the payment.

**CERTIFICATES OF INSURANCE** Where required by law, a certificate of insurance will be delivered to the Policyholder for delivery to each Covered Person. The certificate will list the benefits, conditions and limits of the Policy and will state to whom benefits will be paid.

**CONFORMITY WITH STATE STATUES** Any provision of this Policy which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.