

SERFF Tracking Number: CHUB-126227681 State: Arkansas
Filing Company: Federal Insurance Company State Tracking Number: 43656
Company Tracking Number: 09-AP-9-F
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student
Project Name/Number: Student/09-Ap-9-F

Filing at a Glance

Company: Federal Insurance Company

Product Name: Student

TOI: H04 Health - Blanket Accident/Sickness

Sub-TOI: H04.001 Student

Filing Type: Form

SERFF Tr Num: CHUB-126227681 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43656

Co Tr Num: 09-AP-9-F

Author: Diana Cardone

Date Submitted: 10/01/2009

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 10/05/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Student

Project Number: 09-Ap-9-F

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/05/2009

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Other

Explanation for Other Group Market Type:

Group Student A&S Policy

State Status Changed: 10/05/2009

Created By: Diana Cardone

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Diana Cardone

Filing Description:

Attention: Ms. Rosalinda Minor

Senior Rate & Form Analyst

RE: Student Accident & Sickness Policy

Federal Insurance Company 038-20281

FEIN: 13-1963496

Our Filing #: 09-AP-9-F

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Form #: SH 400-AR

All New Forms

Dear Ms. Minor:

This filing and its attachments serve to submit for your review and approval Chubb's new Student Accident & Sickness policy. It is our belief that this product will meet the needs of our customers and be positively received in the market place.

We are filing one policy (SH 4000-AR) with two variable schedules. One schedule reflects a PPO plan with in-network and out-of-network benefits. The second schedule reflects an indemnity plan with no reference to in- or out-of-network.

This policy will be marketed by Academic Health Plans, Inc. (AHP) out of Colleyville, TX as our broker for schools in Arkansas. AHP has agreements with various PPO networks in Arkansas.

A Certificate of Readability is also enclosed.

Company and Contact

Filing Contact Information

Fran Muldoon, Manager - CPI State Filings fmuldoon@chubb.com
Dept.
202 Hall's Mill Rd. 908-572-2875 [Phone]
P.O. Box 1600 908-572-4034 [FAX]
Whitehouse Station, NJ 08889-9977

Filing Company Information

Federal Insurance Company CoCode: 20281 State of Domicile: Indiana
202 Hall's Mill Road Group Code: 38 Company Type:
P.O. Box 1650 Group Name: State ID Number:
Whitehouse Station, NJ 08889-1650 FEIN Number: 13-1963496
(908) 572-4422 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00

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Retaliatory? No
Fee Explanation: 1 policy X \$50.00 = \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federal Insurance Company	\$50.00	10/01/2009	30982682

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/05/2009	10/05/2009

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	10/02/2009	10/02/2009	Diana Cardone	10/05/2009	10/05/2009

SERFF Tracking Number: CHUB-126227681 *State:* Arkansas
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Disposition

Disposition Date: 10/05/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form (revised)	Policy	Approved-Closed	Yes
Form	Policy	Replaced	Yes
Form	Description of Coverage	Approved-Closed	Yes

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Product Name: Student
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/02/2009
Submitted Date 10/02/2009

Respond By Date

Dear Fran Muldoon,

This will acknowledge receipt of the captioned filing.

Objection 1

- Policy, SH 4000-AR (Form)

Comment:

With respect to adopted children, coverage must be provided for all minors for whom the insured has filed a petition to adopt. Please refer to the 60-day period under ACA 23-79-137.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/05/2009
Submitted Date 10/05/2009

Dear Rosalind Minor,

Comments:

10/05/09

Good Morning Ms. Minor,

This is in reply to your Objection Letter dated 10/2/09.

Response 1

Comments: 10/5/09

We have revised the definition of Dependent Child to reflect that coverage for an adopted child will begin on the date of the filing of a petition of adoption if the application for coverage is within 60 days of the filing of the petition Coverage shall begin at the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the

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birth.

Related Objection 1

Applies To:

- Policy, SH 4000-AR (Form)

Comment:

With respect to adopted children, coverage must be provided for all minors for whom the insured has filed a petition to adopt. Please refer to the 60-day period under ACA 23-79-137.

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	SH 4000-AR		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		59.550	AR Student Health policy REv 10 2 2009).pdf

Previous Version

Policy	SH 4000-AR		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		59.550	AR Student Health policy (Final).pdf
Description of Coverage	SH-7000-AR		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			AR Student Health EOC (10 2 2009).pdf

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No Rate/Rule Schedule items changed.

10/5/09

We trust that our reply including the revised Policy and the Student EOC will be found satisfactory with the DOI and will enable you to continue your review of this program.

Should you require any additional information, please do not hesitate to contact me at 908-572-2872, dcardone@chubb.com or via the SERFF Message Board.

Regards, Diana Cardone

Sincerely,
Diana Cardone

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Form Schedule

Lead Form Number: SH 4000-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/05/2009	SH 4000-AR	Policy/Cont ract/Fratern al	Policy	Initial		59.550	AR Student Health policy REv 10 2 2009).pdf
Approved-Closed 10/05/2009	SH-7000-AR	Policy/Cont ract/Fratern al	Description of Coverage	Initial			AR Student Health EOC (10 2 2009).pdf



STUDENT ACCIDENT & SICKNESS
INSURANCE POLICY

Issued by
Federal Insurance Company

FOR

[POLICYHOLDER]

[Producer: XYZ, Inc.]
[123 Any Street]
[Any town, Any State]
[Attn: John Smith]

Chubb Underwriting Office: Federal Insurance Company
[15 Mountain View Road]
[P O BOX 1615]
[Warren, New Jersey 07061-1615]

*Words and phrases that appear in **bold** print have special meanings and are defined in the Definitions section(s) of this Policy. Defined terms include the plural.*

*Throughout this Policy the words "**We**", "**Us**" and "**Our**" refer to the **Company** providing this insurance.*

Please Read This Policy Carefully

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Insuring Agreement

*Chubb Group of Insurance Companies
15 Mountain View Road, P.O. Box 1615
Warren, New Jersey 07061-1615*

Policyholder's Name and Address:

[University of ABC.]
[123 Main Street]
[PO Box 123245
[Town, State, USA]

Policy Number: [1234-56 - 7890]
Effective Date: [09 - 01 - 2009]
Anniversary Date: [September 1]

*Issued by the stock insurance company
indicated below:*

FEDERAL INSURANCE COMPANY
Incorporated under the laws of
INDIANA

Policy Period

From: [09 - 01 -2009] To: [09-01-2010]
12:01 A.M. standard time at the **Policyholder's** address shown in this Insuring Agreement.

This insurance is provided by the **Company** in consideration of payment of the required premium.

The insurance under this Policy begins on the Effective Date shown above and ends on the last day of the Policy Period shown.

The **Policyholder's** acceptance of this Policy terminates any prior Policy of the same Policy number, effective with the inception of this Policy.

Company

The **Company** issuing this Policy has caused this Policy to be signed by its authorized officers, but this Policy will not be valid unless also signed by a duly authorized representative of the **Company**.

FEDERAL INSURANCE COMPANY (Incorporated under the laws of Indiana)

President

Secretary

Authorized Representative

[Countersigned by :

Licensed Resident Agent]

Premium Summary

Section I - Premium Due Date

[09 -01 - 2009]

Section II - Premium Payment

The **Policyholder** shown in Section I of the Insuring Agreement is responsible for the collection and remittance of all required premiums. Premiums are calculated and payable as follows:

Amount Due:	[Basic and Major Medical Plans]	[Supplemental Plan]
	[\$250] per student for the Fall Semester]	[\$1,050] per student for the Fall Semester]
	[\$300] per student for the Spring Semester and Summer]	[\$1,250] per student for the Spring Semester and Summer]

Schedule of Benefits

*Chubb Group of Insurance Companies
15 Mountain View Road, P.O. Box 1615
Warren, New Jersey 07061-1615*

Policyholder's Name:
[University of ABC.]

*Issued by the stock insurance company
indicated below:*

FEDERAL INSURANCE COMPANY
Incorporated under the laws of
INDIANA

[Section I – Insured Persons

The following are the **Insured Persons** under this Policy:

<u>Class</u>	<u>Description</u>
[1]	[All [Full-Time] [and] [Part-Time] Students of the Policyholder [, including Graduate Students] [and] [International Students]] and their Dependents]

Section II – Medical Benefits

[Class 1] Maximum Benefit Amount per Sickness or Accidental Bodily Injury : [\$50,000] [Basic Plan: [\$3,000]] [Major Medical Plan: [\$50,000]] [Supplemental Plan: [\$250,000]]
[Deductible: [\$50] per Insured Person per Sickness or Accidental Bodily Injury unless shown differently in the table below or in the State Mandated Benefits section of the policy. The annual maximum deductible payable by an Insured Person will not exceed [\$250.] [There is no deductible for services provided at the Student Health Center.]
[Co-Payment : [\$10] per Covered Provider office visit.] [There is no Co-Payment for services provided at the Student Health Center.]
[Insured Percent : [80%] unless shown differently in the table below.] [[100%] for the Basic Plan unless shown differently in the table below.] [[80%] for the Major Medical Plan unless shown differently in the table below.] [[100%] for the Supplemental Plan unless shown differently in the table below.]
[The Pre-Existing Condition exclusion is waived if treatment is provided at the Student Health Center.]

INPATIENT SERVICES:	Preferred Provider	Out of Network
<p>[Hospital Room & Board while Hospital Confined [subject to the daily semi-private room rate including general nursing care provided by the Hospital.] [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] semi-private room rate or Intensive Care Unit room rate] [[80% of] Preferred Allowance [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>	<p>[[60% of] semi-private room rate or Intensive Care Unit room rate] [[60% of] Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>
<p>[Miscellaneous Hospital expenses incurred while Hospital Confined including the cost of the [operating room,] [intensive care,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] Preferred Allowance [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>	<p>[[60% of] Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>
<p>[Hospital expense while Hospital Confined including the cost of the [operating room,] [intensive care,] [room and board,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80%] of Preferred Allowance [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day] [up to a maximum of [20]days]</p>	<p>[60%] of Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day] [up to a maximum of [20]days]</p>
<p>In-Hospital Physician expense. [Does not include expenses for [Surgeon,] [Assistant Surgeon,] [Anesthesiologist] [or] [Second Surgical Opinion.]]</p>	<p>[80% of] Preferred Allowance [\$250 per day] [up to a maximum of [20]days]</p>	<p>[60% of] Reasonable and Customary Charge [\$250 per day] [up to a maximum of [20]days]</p>
<p>Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]</p>	<p>[[80% of] Preferred Allowance] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>	<p>[[60% of] Reasonable and Customary Charge] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>
<p>Assistant Surgeon's fees for services of an assistant surgeon required by the Hospital or by the procedure.</p>	<p>[30%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network) [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>	
<p>Anesthesiologist's fees for services of an anesthesiologist who is not employed or retained by the Hospital in which the surgery is performed.</p>	<p>[30%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network) [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>	

[Registered Nurse Expense for private nursing care]	[[80% of] Preferred Allowance][subject to a maximum of [\$50] per day]] [\$50 per day] [up to a maximum of [20]days]	[[60% of] Reasonable and Customary Charge][subject to a maximum of [\$50] per day]] [\$50 per day] [up to a maximum of [20]days]
[Second Surgical Opinion][or] [Physician Consultation Expense] when a necessary surgical procedure is recommended; conducted by a board certified specialist in the medical field relating to the surgical procedure recommended. This includes x-rays and diagnostic tests.]	[15%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network)	
[Preadmission testing]	[[80%] of Preferred Allowance]	[[60%] of Reasonable and Customary Charge]
[Mental and Nervous Disorder Expenses]	[[80%] of Preferred Allowance to a maximum of [\$400] per day and [\$10,000] per policy term unless shown differently in the Mandate section of the contract.]	[[60%] of Reasonable and Customary Charge to a maximum of [\$400] per day and [\$10,000] per policy term unless shown differently in the Mandate section of the contract.]
OUTPATIENT SERVICES:		
Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Day Surgery Expense: includes services related to scheduled surgery performed in a Hospital including the cost of operating room, [laboratory tests,] [x-rays,] [and] [professional fees].	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Anesthesiologist's fees	[30%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network) [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]	
Covered Provider's Visit Expenses limited to one visit per day.	[[80%] of Preferred Allowance]	[60%] of Reasonable and Customary Charge
[Physiotherapy Treatments for services prescribed by a Physician for a stated number of treatments. For additional treatment, the referring Physician must issue a new prescription following medical evaluation of the Insured Person's condition. Limited to one visit per day.]	[[80%] of Preferred Allowance] [to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]
Medical Emergency Expenses for use of emergency room and supplies. Treatment must be rendered within [72 hours] of an Accidental Bodily Injury or first onset of a covered Sickness .	[80%] of Preferred Allowance [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury] [Co-Payment: [\$100]]	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury] [Co-Payment: [\$100]]
[Diagnostic X-rays and Laboratory Expenses]	[[80%] of Preferred Allowance] [to a maximum of [\$750] per Sickness or	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$750] per

	Accidental Bodily Injury.]	Sickness or Accidental Bodily Injury.]
[Chemotherapy & Radiation Therapy Expenses]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Injection Expenses when administered in a Physician's office and charged on the Physician's statement.]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Tests and Procedures Expenses – diagnostic services and medical procedures performed by a Physician other than Physician visits, physical therapy, x-rays and laboratory procedures.	[80%] of Preferred Allowance [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Mental and Nervous Disorders: includes all ancillary charges incurred as a result of Mental and Nervous Disorders.]	[[80%] of Preferred Allowance [to a maximum of [\$500] per policy term unless shown differently in the Mandate section of the contract.]]	[60%] of Reasonable and Customary Charge [to a maximum of [\$500] per policy term unless shown differently in the Mandate section of the contract.]]
[Ambulance Service Expense for the use of a commercial or municipal Ambulance if an Insured Person requires the use of such Ambulance .]	[Maximum benefit of [\$125] per Accidental Bodily Injury or Sickness . [Deductible of [\$25] per Accidental Bodily Injury or Sickness .]]	
[Dental Expense for removal of impacted wisdom teeth.]	[[80% of] the Preferred Allowance subject to a maximum of [\$100] per tooth.]	[60%] of the Covered Provider's Reasonable and Customary Charge subject to a maximum of [\$80] per tooth.
[Dental Expenses as the result of Accidental Bodily Injury to sound, natural teeth.]	[[80% of] the Preferred Allowance subject to a maximum of [\$100] per tooth.]	[[60% of] the Covered Provider's Reasonable and Customary Charge subject to a maximum of [\$80] per tooth.]
[Consultant Physician's fees (when requested and approved by attending Physician .)]	[[80%] of Preferred Allowance to a maximum of [\$50] per Sickness or Accidental Bodily Injury .]	[[60%] of Reasonable and Customary Charge to a maximum of [\$50] per Sickness or Accidental Bodily Injury .]
[Allergy Treatment Expenses]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Braces and Appliances]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$1,000] per Sickness or Accidental Bodily Injury]	
Arkansas Mandated Benefits	See Section II of the Contract	

]

INPATIENT SERVICES:

<p>[Hospital Room & Board while Hospital Confined [subject to the daily semi-private room rate including general nursing care provided by the Hospital.] [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] Semi-private room rate or Intensive Care Unit room rate [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day [up to a maximum of [20] days]</p>
<p>[Miscellaneous Hospital expenses incurred while Hospital Confined including the cost of the [operating room,] [intensive care,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[100% of] Reasonable & Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day [up to a maximum of [20] days]</p>
<p>[Hospital expense while Hospital Confined including the cost of the [operating room,] [intensive care,] [room and board,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] Semi-private room rate] [[[\$500] per day up to a maximum of [20] days] [[80% of] Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]]</p>
<p>In-Hospital Physician expense. [Does not include expenses for [Surgeon,] [Assistant Surgeon,] [Anesthesiologist] [or] [Second Surgical Opinion.]</p>	<p>[[100% of] Reasonable & Customary Charge] [\$250 per day] [up to a maximum of [20]days]</p>
<p>Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]</p>	<p>[[100% of] Reasonable & Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]]</p>
<p>[Assistant Surgeon's fees for services of an assistant surgeon required by the Hospital or by the procedure.]</p>	<p>[[30%] of the amount paid to the surgeon] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]]</p>
<p>[Anesthesiologist's fees for services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed.]</p>	<p>[[30%] of the amount paid to the surgeon] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]]</p>
<p>[Registered Nurse Expense for private nursing duty care]</p>	<p>[[[100% of] Reasonable & Customary Charge] [[[\$250] per day [up to a maximum of [20] days]</p>
<p>[[Second Surgical Opinion] [or] [Physician Consultation Expense] when a necessary surgical procedure is recommended; conducted by a board certified specialist</p>	<p>[[5%] of the amount paid to the surgeon]</p>

in the medical field relating to the surgical procedure recommended. This includes x-rays and diagnostic tests.]	
[Preadmission testing]	[[60% of] Reasonable & Customary Charge]
[Mental and Nervous Disorders]	[[60% of] Reasonable and Customary Charge to a maximum of [\$400] per day and [\$10,000] per policy term unless shown differently in the Mandate section of the contract.]
OUTPATIENT SERVICES:	
Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]	[100 % of] Reasonable & Customary Charge [subject to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]
Day Surgery Expense: includes services related to scheduled surgery performed in a Hospital including the cost of operating room, [laboratory tests,] [x-rays,] [and] [professional fees].	[100 % of] Reasonable & Customary Charge [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]
[Anesthesiologist's fees for services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed.]	[[30%] of the amount paid to the surgeon] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]
Covered Provider's Visit Expenses limited to one visit per day.	[100 % of] Reasonable & Customary Charge
[Physiotherapy Treatments for services prescribed by a Physician for a stated number of treatments. For additional treatment, the referring Physician must issue a new prescription following medical evaluation of the Insured Person's condition. Limited to one visit per day.]	[100 % of] [Reasonable & Customary Charge] [to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]
Medical Emergency Expenses for use of emergency room and supplies. Treatment must be rendered within [72 hours] of an Accidental Bodily Injury or first onset of a covered Sickness .	[100 %] Reasonable & Customary Charge [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury] [Co-Payment: [\$100]]
[Diagnostic X-rays and Laboratory Expenses]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$750] per Sickness or Accidental Bodily Injury]
[Chemotherapy & Radiation Therapy Expenses]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Injection Expenses when administered in a Physician's office and charged on the Physician's statement.]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Tests and Procedures Expenses – diagnostic services and medical procedures performed by a Physician other than Physician visits, physical therapy, x-rays and laboratory procedures.	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Mental and Nervous Disorders: includes all ancillary charges incurred as a result of Mental and Nervous Disorders.]	[[60%] of Reasonable and Customary Charge to a maximum of [\$500] per policy term unless shown differently in the Mandate section of the contract.]
[Ambulance Service Expense for the use of a commercial or municipal Ambulance if an Insured	[Maximum benefit of [\$125] per Accidental Bodily Injury or Sickness . [Deductible of [\$25] per Accidental

Person requires the use of such Ambulance.]	Bodily Injury or Sickness.]
[Dental Expense for removal of impacted wisdom teeth.]	[[80% of] Reasonable and Customary Charge subject to a maximum of [\$350] per tooth.]
[Dental Expenses as the result of Accidental Bodily Injury to sound, natural teeth.]	[[80% of] Reasonable and Customary Charge subject to a maximum of [\$350] per tooth.]
[Consultant Physician's fees (when requested and approved by attending Physician. .)]	[[60%] of Reasonable and Customary Charge to a maximum of [\$50] per Sickness or Accidental Bodily Injury]
[Allergy Treatment Expenses]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Braces and Appliances]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$1,000] per Sickness or Accidental Bodily Injury]
Arkansas Mandated Benefits	See Section II of the Contract

]

Section III – Accidental Death & Dismemberment Benefits

Accidental:	Benefit Amount:
Loss of Life	[\$3,000]
Loss of Speech and Loss of Hearing	[\$3,000]
Loss of Speech and one of Loss of Hand , Loss of Foot or Loss of Sight of One Eye	[\$3,000]
Loss of Hearing and one of Loss of Hand , Loss of Foot or Loss of Sight of One Eye	[\$3,000]
Loss of Hands (Both), Loss of Feet (Both), Loss of Sight or a combination of any two of Loss of Hand , Loss of Foot or Loss of Sight of One Eye	[\$3,000]
Loss of Hand , Loss of Foot or Loss of Sight of One Eye (Any One of each)	[\$1,500]
Loss of Speech or Loss of Hearing	[\$1,500]
Loss of Thumb and Index Finger of the same hand	[\$750]

[Section IV] [- Medical Evacuation and Repatriation Benefit

[Class] [1]

Medical Evacuation Benefit Amount: [\$10,000]

Repatriation Benefit Amount: [\$10,000]]

[Section V] – Prescription Drug Benefit

[Class 1] Maximum Benefit Amount: [\$700]

[**Co-Payment:** [\$10] per **Insured Person** per generic prescription when using the [Express Scripts card].
[\$20] per **Insured Person** per brand name prescription when using the [Express Scripts card].
[80%] of **Reasonable and Customary Charge** when not using the [Express Scripts card].]]

Contract

SECTION I – INSURANCE

Subject to all the terms and conditions of this Policy and the payment of required premium, We will provide the following insurance.

MEDICAL EXPENSE BENEFITS

We will pay up to the Maximum Benefit Amount per **Sickness** or **Accidental Bodily Injury**, shown in Section II of the Schedule of Benefits, for **Medical Expenses** incurred by an **Insured Person** due to a covered **Accidental Bodily Injury** or **Sickness**. [The Benefit Amount is payable only for **Medical Expenses** incurred within [the policy period] [12 months] after the date of the initial **Sickness** or **Accidental Bodily Injury**]. The Benefit Amount is subject to the [Deductible,] [Co-Payment] [and] [**Insured Percent**] shown in Section II of the Schedule of Benefits.

[If an **Insured Person** receives care from a **Preferred Provider**, **Medical Expenses** will be paid at the **Preferred Provider** level. If a **Preferred Provider** is not available in the **Insured Person's** network area, **Medical Expenses** will be paid at the level of benefits shown as **Preferred Provider**. If the **Medical Expenses** are incurred as the result of an **Emergency**, such **Medical Expenses** will be paid at the **Preferred Provider** level. In all other situations, reduced or lower benefits will be provided when an **Out of Network** provider is used. The benefits payable are as defined in and subject to all provisions of this Policy.]

Benefits will be paid up to the Maximum Benefit for each service as listed in Section II of the Schedule of Benefits.

[Preferred Provider Information]

By enrolling in this Policy, an **Insured Person** has the [PHCS Preferred Provider Network]. The availability of specific providers is subject to change without notice. A complete listing of **Preferred Providers** is available at [www.phcs.com]. The policy does not require an **Insured Person** to use a **Preferred Provider**.]

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

We will pay the applicable Benefit Amount, shown in Section III of the Schedule of Benefits, if an **Accident** results in a covered loss not otherwise excluded. The **Accident** must occur while an **Insured Person** is insured under this policy, while it is in force. The covered **Loss** must occur within [ninety (90) days] after the **Accident**.

[MEDICAL EVACUATION OR REPATRIATION BENEFIT

If an **Insured Person's** **Sickness** or **Accidental Bodily Injury** causes such **Insured Person** to be **Hospital Confined** for [five (5)] or more days, and as a result the **Insured Person** must be **Medically Evacuated**, then We will pay the **Covered Expenses** for such **Medical Evacuation** up to the Benefit Amount for **Medical Evacuation** shown in Section IV of the Schedule of Benefits.

If an **Insured Person's** **Sickness** or **Accidental Bodily Injury** requires the **Repatriation** of the **Insured Person**, then We will pay the **Covered Expenses** for such **Repatriation** up to the Benefit Amount for **Repatriation** shown in Section IV of the Schedule of Benefits.

The **Medical Evacuation** or **Repatriation** must be recommended by the attending **Physician** and approved and arranged by **Our Assistance Services Administrator**. The Benefit Amount for **Medical Evacuation** or **Repatriation** is payable in addition to any other applicable Benefit Amounts under this policy.]

[PRESCRIPTION DRUG BENEFIT

We will pay for Covered **Prescription Drugs** as a result of **Sickness** or **Accidental Bodily Injury** up to the maximum Benefit Amount shown in Section [V] of the Schedule of Benefits. The Benefit Amount is subject to the **Co-Payment** shown in Section [V] of the Schedule of Benefits.]

SECTION II – ARKANSAS STATE MANDATED INSURANCE BENEFITS

Subject to all the terms and conditions of this Policy and the payment of required premium, We will provide the following Mandated Benefits and any other applicable mandate in accordance with Arkansas insurance laws.

[ALCOHOL AND DRUG DEPENDENCY BENEFIT

We will pay expenses incurred for the **Necessary Care and Treatment** of alcohol and other drug dependency that are not less favorable than for physical illness generally. For each 24 month period We will pay a minimum of \$6,000 for the **Necessary Care and Treatment** of alcohol or drug dependency. No more than half of the maximum benefit amount for alcohol or drug dependency for a twenty-four (24) month period shall be paid for the **Necessary Care and Treatment** of alcohol or drug dependency in any thirty (30) consecutive day period.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

[BREAST RECONSTRUCTION AND MASTECTOMY BENEFIT

We will pay expenses incurred for:

- 1) medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than forty-eight (48) hours unless the decision to discharge the patient before the expiration of the minimum length of stay is made by the attending **Physician** in consultation with the **Insured Person**;
- 2) reconstructive surgery on each breast for which a mastectomy has been performed;
- 3) reconstructive surgery on a non-diseased breast to provide a symmetrical appearance;
- 4) prostheses; and
- 5) physical complications during all stages of a mastectomy, including lymphedemas.]

CANCER DRUG BENEFIT

We will pay expenses incurred for drugs to treat cancer provided that:

- 1) such drugs have been approved for sale by the federal Food and Drug Administration; and
- 2) the drug is recognized as safe and effective for treatment of the specific type of cancer for which it has been prescribed in:
 - a) any of the following standard reference compendia:
 - i) The American Hospital Formulary Service Drug Information;
 - ii) The National Comprehensive Cancer Network Drugs and Biologics Compendium; or
 - iii) The Elsevier Gold Standard's Clinical Pharmacology; or
 - b) two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature; or
 - c) other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner.

We will also pay expenses incurred for the administration of the drug. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

CHILDREN'S PREVENTIVE HEALTH CARE SERVICES BENEFIT

We will pay expenses incurred for **Children's Preventive Care Services** for an **Insured Person's** child who is insured under this **Policy**, for twenty (20) visits at the following intervals:

- 1) six (6) times during the child's first year after birth;
- 2) three (3) times during the next year; and
- 3) annually until age eighteen (18).

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

COLORECTAL CANCER EXAMINATION BENEFIT

We will pay expenses incurred for colorectal cancer examinations and laboratory tests for:

- 1) **Insured Persons** who are fifty (50) years of age or older;
- 2) **Insured Persons** who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
- 3) **Insured Persons** experiencing the following symptoms of colorectal cancer as determined by a **Physician** and:
 - a) bleeding from the rectum or blood in the stool; or
 - b) a change in bowel habits that lasts more than five (5) days.

The colorectal screening shall involve an examination of the entire colon, including the following examinations or laboratory tests, or both:

- 1) an annual fecal occult blood test or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) a double –contrast barium enema every five (5) years; or
- 3) a colonoscopy every ten (10) years; and
- 4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up surgery:

- 1) if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
- 2) for **Insured Persons** with one (1) or more neoplastic polyps or adenomatous polyps, follow-up is recommended in three (3) years;
- 3) if single tubular adenoma of less than one centimeter (1cm) is found, follow-up is recommended in five (5) years; and
- 4) for **Insured Persons** with large sessile adenomas greater than three centimeters (3cm), follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

[CONTRACEPTIVES BENEFIT

We will pay expenses incurred for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.]

DENTAL CARE BENEFIT

We will pay expenses incurred for anesthesia and hospital or ambulatory surgical facility charges for services provided in conjunction with dental care that is provided to an **Insured Person** if:

- 1) the **Insured Person's Physician** certifies that because of the **Insured Person's** age or condition, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and
- 2) the **Insured Person** is a child age seven (7) or under who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act, §17-82-101, et seq., to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
- 3) the **Insured Person** has been diagnosed with a serious mental or physical condition; or
- 4) the **Insured Person** has a significant behavioral problem as determined by the **Insured Person's Physician**.

DIABETES COVERAGE BENEFIT

We will pay expenses incurred for laboratory and diagnostic tests for all types of diabetes. In addition We will pay for expenses incurred for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. Such coverage includes **Diabetes Equipment**, in accordance with the **Insured Person's** treatment plan, drugs and supplies prescribed by a prescribing **Physician**. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

DIABETES SELF-MANAGEMENT TRAINING BENEFIT

We will pay expenses incurred for self-management training provided by an appropriately licensed health care professional who has completed an educational program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Coverage is limited to one (1) training program per lifetime per **Insured Person**. Additional diabetes self-management training may be

provided in the event the **Insured Person's Physician** prescribes additional diabetes self-management training and is needed because of a significant change in the **Insured Person's** symptoms or conditions. Diabetes self-management training shall be provided only upon prescription by the **Insured Person's Physician**.

HEARING AID BENEFIT

We will pay expenses incurred for a hearing aid or hearing instrument sold by a professional licensed by the state to dispense a hearing aid or hearing instrument. The benefit is limited to [\$1,400] per ear every three years.

[HOSPICE CARE BENEFIT

We will pay expenses incurred for **Hospice** services to a terminally ill **Insured Person** who has a life expectancy of six (6) months or less. **Hospice** services include, but are not limited to:

- 1) **Physician's** services;
- 2) care provided by or under the supervision of a nurse;
- 3) social services, volunteer services and counseling services provided by professional or volunteer staff under professional supervision.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.]

IN VITRO FERTILIZATION BENEFIT

We will pay the expenses incurred for in vitro fertilization services performed at:

- 1) a medical facility licensed or certified by the Department of Health;
- 2) a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics; or
- 3) a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilizations.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

[MAMMOGRAPHY BENEFIT

We will pay expenses incurred for mammographic examinations as follows:

- 1) a baseline mammogram for women who are thirty-five (35) to forty (40) years of age;
- 2) a mammogram for women who are forty (40) to forty-nine (49) years of age every one (1) to two (2) years based on the recommendation of the woman's **Physician**; and
- 3) a mammogram every year for women who are fifty (50) years of age or older.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.]

MATERNITY AND NEWBORN BENEFIT

We will pay expenses incurred for inpatient care for mother and newborn in a health care facility for:

- 1) forty-eight (48) hours following a normal vaginal delivery; or
- 2) ninety-six (96) hours following a caesarean delivery.

We will also pay expenses incurred for newborn testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS BENEFIT

We will pay expenses incurred for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a **Physician** for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the cost of the medical food or low protein modified food products for an **Insured Person** or an **Insured Person's Dependent** exceeds the income tax credit of \$2,400.00 per year per person allowed under §23-79-702. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

MENTAL ILLNESS BENEFIT

We will pay expenses incurred for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of those with developmental disorders. Benefits for the diagnosis and mental health treatment of mental illnesses and developmental disorders will be paid under the same terms and conditions as provided for the treatment of other medical illnesses or conditions.

[MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD BENEFIT

We will pay expenses for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and non-surgical procedures. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.]

PROSTATE CANCER SCREENING BENEFIT

We will pay expenses incurred for one (1) screening per year for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines. Such screening must be performed by a qualified medical professional. If a qualified medical professional recommends that an **Insured Person** undergo a prostate specific antigen blood test, **We Will** pay the expenses incurred for such test even if the **Insured Person** had a digital rectal examination and the examination result was negative. This benefit is not subject to a deductible.

SPEECH, HEARING AND LANGUAGE BENEFIT

We will pay expenses incurred for the diagnosis and treatment of loss or impairment of speech or hearing. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

Limitation on Speech, Hearing and Language Benefit

Coverage does not apply to hearing instruments or devices.

SECTION III - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

Eligibility

A person becomes insured under this Policy if such person is a member of an eligible Class of **Insured Persons** as shown in Section I of the Schedule of Benefits. **We** have the right to investigate student status and attendance records to verify that the eligibility requirements have been met.

Effective Date of Insurance for an Insured Person

Insurance for an **Insured Person** becomes effective on the latest of:

- 1) the effective date of this Policy;
- 2) the date on which such person first meets the eligibility criteria as an **Insured Person**; or
- 3) the beginning of the period for which required premium is paid for such **Insured Person**, except that:
 - a) for a newborn child, coverage will begin from the moment of birth. Payment of the required premium for newborn children must be furnished to **Us** within ninety (90) days after the date of birth in order to continue coverage beyond such ninety (90) day period;
 - b) for an adopted child, coverage will begin upon the date of placement by a licensed placement agency of the child for purposes of adoption in the home of an **Insured Person**. Payment of the required premium for adopted children must be furnished to **Us** within thirty-one (31) days of the petition date or placement date in order to continue coverage beyond such thirty-one (31) day period; and
 - c) for a spouse [or domestic partner], coverage will begin on the date of marriage [or on the date of the civil union] to the **Insured Person**. Payment of the required premium for the spouse [or domestic partner] must be furnished to **Us** within thirty-one (31) days after the date of marriage [or the date of the civil union] in order to continue coverage beyond such thirty-one (31) day period.

Termination of Insurance for an Insured Person

Insurance for an **Insured Person** automatically terminates on the earliest of:

- 1) the termination date of this Policy;
- 2) the expiration of the period for which required premium has been paid for such **Insured Person**;
- 3) the date on which a person no longer meets the eligibility criteria as an **Insured Person**;
- 4) the last date of the period for which premium has been paid following the date a **Dependent** ceases to be a **Dependent** as defined.

Termination is subject to the Extension of Benefits provision.

Partial Year Enrollment/Refund of Premium

Except for medical withdrawal due to a covered **Accidental Bodily Injury** or **Sickness**, any student withdrawing from school during the first thirty-one (31) days of the period for which coverage is purchased will not be insured under the Policy and a full refund of the premium will be made. Students withdrawing after such thirty-one (31) day period will remain covered under the Policy for the full period for which premium has been paid and no refund will be allowed.

Insured Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the **Company** [within ninety (90) days of entry into the armed forces].

Continuation of Benefits

We will continue to pay benefits under the policy for an **Insured Person** who is hospitalized on the date of termination if the policy is terminated and replaced by a group policy issued by another insurer. Any payment required is subject to all terms, limitations and conditions of the policy except those relating to termination of SH 4000-AR

benefits. Any obligation by us will continue until the hospital confinement ends of hospital benefits under the policy are exhausted, whichever is earlier.

Continuation of Coverage

Insured Persons, and their eligible **Dependents**, whose insurance has terminated because they are no longer a member of the group or because there is a change in marital status shall be entitled to continue their coverage provided the following:

1. the **Insured Person** has been continuously insured under the policy during the entire three (3) month period prior to the termination of membership or change in marital status;
2. the **Insured Person** is not or can not be covered by Medicare or any other group accident and health policy.
3. the **Insured Person** must request such continuation in writing within ten (10) days of the date coverage would otherwise terminate and must pay to the **Policyholder**, on a monthly basis, the amount of contribution required to continue coverage.

Continuation of coverage will end upon the earliest of the following dates:

1. one hundred twenty (120) days after the continuation of coverage began;
2. the end of the period for which the **Insured Person** made a timely contribution;
3. the contribution due date following the date the **Insured Person** becomes eligible for Medicare; or
4. the date on which the policy is terminated or the group withdraws from the plan.

SECTION IV –EXCLUSIONS AND LIMITATIONS

The following exclusions apply to all Benefits and Hazards. Additional exclusions, limitations or conditions may also apply to specific Benefits or Hazards. Please read this entire Policy carefully.

Insurance does not apply to any **Loss** or **Medical Expense** which results from:

1. any treatment, service or supply that is not required for the care and treatment of **Accidental Bodily Injury** or **Sickness**, or any service, treatment or supply that is not recommended by the attending **Covered Provider**;
2. **Elective Surgery or Elective Treatment**;
3. any treatment, service or supply that is **Experimental or Investigational**;
4. cosmetic surgery or treatments;
5. a **Pre-existing Condition** that results in any service, treatment or supply within the first six (6) months following the **Insured Person's** effective date of coverage under this Policy unless during the period immediately preceding the **Insured Person's** effective date under this Policy, the **Insured Person** was covered under prior **Creditable Coverage** for at least six (6) months. **Creditable Coverage** of less than six (6) months will be credited toward satisfying this **Pre-Existing Condition** exclusion;
6. any treatment, service or supply that is provided normally without charge by the **Policyholder's** health center, infirmary or **Hospital**, [or by any person employed by or contracted with the **Policyholder** [including team **Physicians** and trainers]];
7. any treatment, service or supply that is provided in a government **Hospital** unless there is a legal obligation to pay such charges in the absence of other insurance;
8. any treatment, service or supply which is received without charge or legal obligation to pay or would not routinely be paid in the absence of insurance;
9. any treatment, service or supply that is provided by an **Insured Person's Immediate Family Member**;
10. **Accidental Bodily Injury** or **Sickness** for which benefits are payable under any Workers Compensation or Occupational Disease Law, Employers Liability Law, Public Assistance Programs or Occupational Benefit Plans;
11. a motor vehicle **Accident** for which benefits are payable from other valid insurance;
12. declared or undeclared **War**;
13. **Accidental Bodily Injury** sustained or **Sickness** contracted while the **Insured Person** is participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to Reserve or National Guard active duty for training unless it extends beyond thirty-one (31) days;
14. [treatment occurring outside of the United States;]
15. routine physical examinations, preventive testing or treatment, screening exams or testing in the absence of **Sickness** or **Accidental Bodily Injury** unless specifically covered elsewhere in the Policy;
16. expenses for preventative medicines, vaccines, [or **Prescription Drugs**] unless specifically covered elsewhere in the Policy;
17. [**Prescription Drugs**, services or supplies as follows:
 - a. therapeutic devices or appliances, including hypodermic needles or syringes prescribed by a **Physician** for the purpose of administering medications for medical conditions, provided such medications are not

- covered under the Policy, support garments and other non-medical substances;
- b. immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - c. drugs labeled **Experimental or Investigational**;
 - d. anabolic steroids used for body building;
 - e. drugs used to treat or cure baldness;
 - f. drugs used for the purpose of weight control;
 - g. growth hormones;
 - h. refills in excess of the number specified or dispensed after one year of the date of prescription;]
18. [**Off-Label Drug Use** unless specifically covered elsewhere in the Policy;]
 19. dental treatment, except for treatment (a) for the removal of impacted wisdom teeth or (b) resulting from **Accidental Bodily Injury** to sound, natural teeth;
 20. prescriptions and examinations for, or repair and replacement of, eyeglasses or contact lenses;
 21. [hearing examinations or hearing aids or other treatment for hearing defects and problems, except for newborn hearing for the first thirty-one (31) days of coverage. Hearing defects means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;]
 22. [orthopedic appliances, orthotics or other devices used for treatment of a foot or conditions relating to a foot including but not limited to weak, strained or flat feet, corns, calluses, bunions, or toenails;]
 23. an **Insured Person's** commission or attempted commission of any illegal act including but not limited to any felony;
 24. [an **Insured Person** being intoxicated. Intoxication is defined by the laws of the jurisdiction where treatment is received;]
 25. [an **Insured Person** being under the influence of any narcotic or other controlled substance unless such narcotic or other controlled substance is taken and used as prescribed by a **Physician**;]
 26. [sex changes, sexual enhancement drugs, sexual dysfunctions or inadequacies with the exception of penile prosthesis required for physiological impotence;]
 27. [suicide, attempted suicide, self-inflicted injury or attempted self-inflicted injury unless covered under benefits for Mental Illness;]
 28. completion of forms by the **Covered Provider** or fees for appointments scheduled and not kept;
 29. [treatment for smoking cessation;]
 30. [addiction and co-dependency treatment, services or supplies unless specifically covered elsewhere in the Policy;]
 31. [weight management, weight reduction, nutrition programs, treatment for obesity, or surgery for removal of excess skin or fat;]
 32. [over-the-counter medication or **Durable Medical Equipment** unless specifically covered elsewhere in the Policy;]
 33. membership fees to a spa or health club, fitness training or exercise equipment;
 34. [rest cures, custodial care or non-medical care;]

35. [maintenance therapy which is defined as those therapy services rendered to an **Insured Person** who is no longer making documentable progress to maintain the level of progress previously attained;]
36. [an **Insured Person's** participation in intercollegiate or professional sports, including practice, conditioning, play and travel;]
37. [an **Insured Person** riding as a passenger in, entering or exiting any aircraft, except as a fare-paying passenger in an aircraft owned or operated by a **Scheduled Airline**;]
38. [a motor vehicle **Accident** if the **Insured Person** is not properly licensed to operate the motor vehicle within the jurisdiction in which the **Accident** takes place [, except in a Driver's Education Program]. [This exclusion will not apply to passengers if they are **Insured Persons** under this Policy;]
39. [**Accidental Bodily Injury** resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle [and/or off-road four-wheeled motorized vehicles]), [personal water craft or bungee jumping;]]
40. the **Insured Person** engaging in or participating in a motorized vehicular race or speed contest including training or practice;
41. the **Insured Person** engaging in or participating in scuba diving to depths of more than 100 feet; skydiving; hang-gliding or para-gliding; parascending other than over water; bungee jumping; mountaineering or rock climbing normally requiring the use of guides or ropes; or caving;
42. [injury resulting from fighting, except in self-defense.]

With respect to **Accidental** Death & Dismemberment Benefit only, the following exclusion also applies:

Insurance does not apply to any **Accident, Accidental Bodily Injury** or **Loss** caused by or resulting from the **Insured Person's** emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to an **Insured Person's** bacterial infection caused by an **Accident** or **Accidental** consumption of a substance contaminated by bacteria.

SECTION V - DEFINITIONS

For the purpose of these definitions, the singular includes the plural and the plural includes the singular, unless otherwise noted. Male pronouns whenever used include female pronouns.

Accident or Accidental

Accident or **Accidental** means a sudden, unforeseen, and unexpected event which:

- 1) happens by chance;
- 2) is independent of illness, disease or other bodily malfunction or medical or surgical treatment thereof;
- 3) occurs while the **Insured Person** is insured under this policy which is in force; and
- 4) is the direct cause of loss.

Accidental Bodily Injury

Accidental Bodily Injury means bodily injury, which:

- 1) is **Accidental**;
- 2) is the direct cause of a loss; and
- 3) occurs while an **Insured Person** is insured under this Policy, which is in force.

Ambulance

Ambulance means a vehicle which is licensed solely as an **Ambulance** by the local regulatory body to provide transportation to a **Hospital** or transportation from one **Hospital** to another for those individuals who are unable to travel to receive medical care by any other means or the **Hospital** cannot provide the needed care. **Emergency** transportation includes **Ambulance** services provided through the "911" **Emergency** response system.

[Assistance Services Administrator

Assistance Services Administrator means the organization that contracts with the **Company** to provide **Medical Evacuation** and **Repatriation** services to an **Insured Person**.]

Children's Preventive Health Care Services

Children's Preventive Health care Services means **Physician**-delivered or **Physician**-supervised services for an **Insured Person's** child from birth through eighteen (18) years of age, with **Periodic Preventive Care Visits**, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests.

Company

Company means Federal Insurance Company.

Complications of Pregnancy

Complications of Pregnancy means:

- 1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and
- 2) nonelective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include:

- 1) false labor;
- 2) occasional spotting;
- 3) **Physician** prescribed rest during the period of pregnancy;
- 4) morning sickness;
- 5) hyperemesis gravidarum;
- 6) pre-eclampsia; or
- 7) similar conditions associated with the management of a difficult pregnancy but which are not distinctly related to the pregnancy.

[Conveyance

Conveyance means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.]

[Co-Payment

Co-Payment means the charge payable by the **Insured Person** for certain **Medical Expenses**.

[Covered Expenses

With respect to **Medical Evacuation**, **Covered Expenses** means the cost for:

- 1) a land, water or air **Conveyance**, required to transport an **Insured Person** during a **Medical Evacuation**. Special transportation by, but not limited to, air ambulances, land ambulances and private motor vehicles must:
 - a) be recommended by an attending **Physician**; and
 - b) comply with the standard regulations of the **Conveyance** transporting an **Insured Person**.

The means of transportation that is best suited to accommodate an **Insured Person**, based on the seriousness of an **Insured Person's** condition, will be used.

- 2) medical supplies and services which are:
 - a) ordered or prescribed by an attending **Physician**; and
 - b) are, in the opinion of an attending **Physician**, necessarily incurred in connection with the **Medical Evacuation** of an **Insured Person**.

With respect to **Repatriation**, **Covered Expenses** means the cost for:

- 1) **Repatriation** of an **Insured Person**; and
- 2) medical supplies and services which:
 - a) are ordered or prescribed by an attending **Physician**; and
 - b) are, in the opinion of an attending **Physician**, necessarily incurred in connection with **Repatriation** of an **Insured Person**; or
 - c) are necessary for embalming, cremation, transportation and purchase of a shipping container as required by applicable law or regulation.

With respect to **Medical Evacuation** and **Repatriation**, all transportation arrangements made for an **Insured Person** will be by the most direct and economical route. All **Covered Expenses** must be arranged by and receive the prior approval of **Our Assistance Service Administrator**.

Covered Expenses do not include those expenses incurred by an **Insured Person** for **Sickness** or **Accidental Bodily Injury** which occurs while an **Insured Person** is:

- 1) traveling against the advice of a **Physician**; or
- 2) traveling for the purpose of obtaining medical treatment.]

[Covered Provider

Covered Provider means a:

- 1) **Physician**;
- 2) **Licensed Mental Health Professional**;
- 3) psychotherapist;
- 4) chiropractor acting within the scope of his or her license;
- 5) physical therapist;
- 6) dentist while providing oral surgical care, services, procedures or benefits covered by this policy;
- 7) podiatrist;
- 8) optometrist while providing visual services which are covered by this policy;
- 9) certified nurse midwife while acting within the lawful scope of practice for a certified nurse midwife;
- 10) certified registered nurse anesthetist or nurse practitioner designated as such by the board of registration in nursing while providing services that are within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice;
- 11) **Physician** assistant performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioner.

Covered Provider does not include an **Insured Person** or an **Immediate Family Member** of an **Insured Person**.

Creditable Coverage

Creditable Coverage means insurance under any of the following health plans with no lapse in coverage of more than sixty-three (63) days during the period immediately preceding the **Insured Person's** effective date under this Policy:

- 1) a group health plan;
- 2) a health plan, including but not limited, to a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program;
- 3) Part A or Part B of Title XVIII of the Social Security Act, as amended;
- 4) Title XIX of the Social Security Act, as amended, other than coverage consisting solely of benefits under section 1928;
- 5) 10 U.S.C. chapter 55, as amended;
- 6) a medical care program of the Indian Health Service or of a tribal organization;
- 7) a state health benefits risk pool;
- 8) a health plan offered under 5 U.S.C. chapter 89, as amended;
- 9) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701 (c)(I)(I), as amended by Public Law 104-191; or
- 10) a health benefit plan under the Peace Corps Acts, 22 U.S.C. 2504(e), as amended; or
- 11) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

Creditable Coverage includes continuation coverage but does not include **Accident-only**, credit, coverage for on-site medical clinics, disability income, **Medicare** supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Dependent

Dependent means the **Insured Person's Dependent Child**, [or] **Spouse** [, or **Domestic Partner**]

Dependent Child

Dependent Child means an **Insured Person's** unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of the filing of a petition of adoption if the application for coverage is within sixty (60) days of the filing of the petition Coverage shall begin at the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth. The **Dependent Child** must be primarily dependent upon such **Insured Person** for maintenance and support, and must be:

- 1) under the age of [nineteen (19)];
- 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an **Institution of Higher Learning**; or
- 3) classified as an **Incapacitated Dependent Child**.

Diabetes Equipment

Diabetes Equipment means:

- 1) blood glucose monitors;
- 2) blood glucose monitoring strips for home use;
- 3) voice-synthesizers for blood glucose monitors for use by the legally blind;
- 4) visual magnifying aids for use by the legally blind;
- 5) urine glucose strips;
- 6) ketone strips;
- 7) lancets;
- 8) insulin and insulin syringes;
- 9) insulin pumps and insulin pump supplies and insulin pens;
- 10) therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating **Physician** and prescribed by a podiatrist or other qualified **Physician** and furnished by a podiatrist, orthotist, prosthetist or pedorthist.

Domestic Partner

Domestic Partner means a person designated by an **Insured Person** who is registered as a **Domestic Partner** or legal equivalent under laws of the governing jurisdiction or who:

- 1) is at least [eighteen 18] years of age and competent to enter into a contract;
- 2) is not related to the **Insured Person** by blood;
- 3) has exclusively lived with the **Insured Person** for at least [one (1) year] prior to the date of enrollment;
- 4) is not legally married or separated; and
- 5) as of the date of enrollment, has with the **Insured Person** at least two (2) of the following financial arrangements:
 - a) a joint mortgage or lease;
 - b) a joint bank account;
 - c) joint title to or ownership of a motor vehicle or status as a joint lessee on a motor vehicle lease; or
 - d) a joint credit card account with a financial institution.

Neither the **Insured Person** nor the **Domestic Partner** can be married to, nor in a civil union with, anyone else.

Durable Medical Equipment

Durable Medical Equipment means equipment that can be expected to make a meaningful contribution to the **Insured Person's Accidental Bodily Injury** or **Sickness** and is:

- 1) primarily and customarily used for medical purposes;
- 2) equipped with features and functions that are generally not required in the absence of an **Accidental Bodily Injury** or **Sickness**;
- 3) routinely used in a **Hospital** but also used effectively in a non-medical facility; and
- 4) prescribed by a **Covered Provider** for the **Insured Person's** rehabilitation.]

Elective Surgery or Elective Treatment

Elective Surgery or Elective Treatment means any surgery or treatment that:

- 1) is not necessitated by a pathological or traumatic change in the function or structure of any part of the body;
- 2) is for the **Insured Person's** convenience; and
- 3) does not require immediate attention.

Emergency

Emergency means the unexpected onset of an **Accidental Bodily Injury** or **Sickness** which requires immediate or urgent medical attention which, if not provided, could result in a loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. **Emergency** does not include **Elective Surgery or Elective Treatment** or routine care.

Emergency Medical Treatment

Emergency Medical Treatment means **Hospital** treatment for a medical condition which:

- 1) arises suddenly and unexpectedly; and
- 2) if left untreated could result in loss of life, or in serious deterioration of an **Insured Person's** medical condition.]

Experimental or Investigational

Experimental or Investigational means any drug, device or medical treatment (collectively “Technology”) that satisfies any of the following criteria:

- 1) the Technology cannot be lawfully marketed within the United States without the approval of the U.S. Food and Drug Administration (“FDA”) and the FDA has given no approval to market the Technology at the time the Technology is furnished;
- 2) the Technology for the particular diagnosis or set of indications is:
 - (a) the subject of ongoing Phase I or II clinical trials; or
 - (b) the investigational arm of a Phase III study or under study to determine its:
 - (i) maximum tolerated dosage;
 - (ii) efficacy;
 - (iii) safety; or
 - (iv) toxicity compared with the standard means of treatment or diagnosis.
- 3) as demonstrated by **Medical Evidence**, expert opinion regarding the Technology has formed a consensus that further studies or clinical trials are necessary to determine the Technology’s:
 - (a) maximum tolerated dosage;
 - (b) efficacy;
 - (c) safety, or
 - (d) toxicity compared with the standard means of treatment or diagnosis;
- 4) the Technology was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

Any treatment that results from an **Experimental or Investigational** Technology will also be considered **Experimental or Investigational**.

[Hospice

Hospice means a centrally coordinated program ensuring continuity and consistency of home and inpatient care provided directly through an inpatient facility operating under its hospice license or through an agreement.]

Hospital

Hospital means a public or private institution which:

- 1) is licensed in accordance with the laws of the jurisdiction where it is located;
- 2) is accredited by the Joint Commission on Accreditation of Hospitals;
- 3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- 4) provides organized facilities for diagnosis and medical or surgical treatment;
- 5) provides twenty-four (24 hour) nursing care;
- 6) has a **Physician** or staff of **Physicians** ; and
- 7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.

Hospital Confined or Hospital Confinement

Hospital Confined or **Hospital Confinement** means a stay of eighteen (18) or more consecutive hours as a resident bed-patient in a **Hospital**.

Immediate Family Member

Immediate Family Member means an **Insured Person’s**:

- 1) **Spouse** or **Domestic Partner**;
- 2) children including adopted children or stepchildren;
- 3) legal guardians or wards;
- 4) siblings or siblings-in-law;
- 5) parents or parents-in-law;
- 6) grandparents or grandchildren;
- 7) aunts or uncles;
- 8) nieces and nephews.

Immediate Family Member also means a **Spouse's** or **Domestic Partner's** children, including adopted children or stepchildren; legal guardians or wards; siblings or siblings-in-law; parents or parents-in-law; grandparents or grandchildren; aunts or uncles; nieces or nephews.

Incapacitated Dependent Child

Incapacitated Dependent Child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on an **Insured Person** for support and maintenance. The incapacity must have occurred while the child was:

- 1) under the age of [nineteen (19)]; or
- 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an **Institution of Higher Learning**.

Institution of Higher Learning

Institution of Higher Learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12th) grade.

Insured Percent

Insured Percent means the percentage of **Medical Expenses** that **We** pay for each **Accidental Bodily Injury** or **Sickness**.

Insured Person

Insured Person means a person:

- 1) who is eligible for coverage as the insured or as a **Dependent**;
- 2) who has been accepted for coverage or has been automatically added;
- 3) who has paid the required premium; and
- 4) whose coverage has become effective and has not terminated.

Intensive Care

Intensive Care means treatment in an **Intensive Care Unit**.

Intensive Care Unit

Intensive Care Unit means a specifically designed facility of the **Hospital** that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit.

Intensive Care Unit does not mean any of the following step-down units:

- 1) progressive care;
- 2) sub-acute intensive care;
- 3) intermediate care units;
- 4) private monitored rooms;
- 5) observation units; or
- 6) other facilities which do not meet the standards for intensive care.

Licensed Mental Health Professional

Licensed Mental Health Professional means a:

- 1) **Physician** who specializes in the practice of psychiatry;
- 2) licensed psychologist;
- 3) licensed independent clinical social worker;
- 4) licensed mental health counselor; or
- 5) licensed nurse mental health clinical specialist.

Loss

Loss means **Accidental: Loss of Foot, Loss of Hand, Loss of Hearing, loss of life, Loss of Sight, Loss of Sight of One Eye, Loss of Speech, and Loss of Thumb and Index Finger** which occurs within [ninety (90) days] after the **Accident**.

Loss of Foot

Loss of Foot means the complete severance of a foot through or above the ankle joint. **We** will consider such severance a **Loss of Foot** even if the foot is later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.

Loss of Hand

Loss of Hand means complete severance, as determined by a **Physician**, of at least four (4) fingers at or above the metacarpal phalangeal joint on the same hand or at least three (3) fingers and the thumb on the same hand. **We** will consider such severance a **Loss of Hand** even if the hand, fingers or thumb are later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.

Loss of Hearing

Loss of Hearing means permanent, irrecoverable and total deafness, as determined by a **Physician**, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a **Physician**.

Loss of Sight

Loss of Sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a **Physician**.

Loss of Sight of One Eye

Loss of Sight of One Eye means permanent loss of vision of one eye. Remaining vision in that eye must be no better than 20/200 using a corrective aid or device, as determined by a **Physician**.

Loss of Speech

Loss of Speech means the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices, as determined by a **Physician**.

Loss of Thumb and Index Finger

Loss of Thumb and Index Finger means complete severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand, as determined by a **Physician**. **We** will consider such severance a **Loss of Thumb and Index Finger** even if a thumb, an index finger or both are later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.

Medicaid

Medicaid means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as then constituted or later amended.

[Medical Evacuation or Medically Evacuated

Medical Evacuation or Medically Evacuated means the emergency transportation of an **Insured Person** from the location where such **Insured Person** is injured or becomes ill to the nearest **Hospital** where appropriate medical care and treatment can be provided.]

Medical Evidence

Medical Evidence means:

- 1) a published report, a clinical study, or a review article in a peer-reviewed professional medical or scientific journal;
- 2) written protocols used by a facility studying a drug, device or medical treatment that is substantially identical to the drug, device or medical treatment furnished; or
- 3) written informed consent used by a facility studying a drug, device or medical treatment that is substantially identical to the drug, device or medical treatment furnished.

Medical Expenses

Medical Expenses means the **Reasonable and Customary Charges** for any medical treatment, service or supply given by a **Covered Provider** that is:

- 1) not in excess of the maximum amount payable for services as specified in the Schedule of Benefits;
- 2) not in excess of the charges that would have been made in the absence of this insurance;
- 3) incurred while this Plan is in force as to the **Insured Person**; and
- 4) in excess of any deductible amount.

Medicare

Medicare means the government program established to provide health care benefits including Part A and Part B as established by Title XVIII of the Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Necessary Care and Treatment

Necessary Care and Treatment means treatment, including detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, in an alcohol or drug dependency treatment facility or care and treatment in a hospital.]

Occupational Therapy

Occupational Therapy means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a **Physician** who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan must be reviewed and certified at least every two (2) months by such **Physician**.

[Off-Label Drug Use

Off-Label Drug Use means the use of a drug for the purpose other than that for which it was approved by the U.S. Food and Drug Administration (FDA). **Off-Label Drug Use** does not mean a drug:

- 1) that has been approved by the FDA at the time the drug is furnished; and
- 2) which is necessary for the prescribed indication; and
- 3) which is supported by adequate medical and scientific evidence as being safe and effective for the prescribed indication, as noted in the Centers for Medicare & Medicaid Services approved compendia, or in a well-recognized major peer reviewed medical journal, or in the published results of a clinical trial presenting data that supports the use as safe and effective.]

[Out-of-Network

Out-of-Network means providers who have not agreed to any prearranged fee schedules.]

Periodic Preventive Care Visits

Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Physician

Physician means a licensed practitioner of the healing arts, acting within the scope of his or her license to the extent provided by the laws of the jurisdiction in which medical treatment is provided. **Physician** does not include an **Insured Person**, or an **Immediate Family Member** of an **Insured Person**.

Physiotherapy

Physiotherapy means treatment provided by a licensed Physical Therapist.

Policyholder

Policyholder means the entity identified in the Insuring Agreement.

Pre-Existing Condition

Pre-Existing Condition means a **Sickness** or **Accidental Bodily Injury** which, during the six (6) month period prior to the **Insured Person's** effective date of coverage under this Policy, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical

advice, diagnosis, care or treatment was recommended or received. **Pre-Existing Condition** does not include pregnancy.

Preferred Allowance

Preferred Allowance means the amount a **Preferred Provider** will accept as payment in full for **Medical Expenses**.]

Preferred Provider

Preferred Provider means the **Covered Providers** and **Hospitals** who have contracted to provide specific medical care at negotiated prices. **Preferred Providers** in the local school area are: [NEHCA HMO-PP0 Hospitals and Physicians].]

Prescription Drug

Prescription Drug means medication that, under U.S. Federal law, may only be dispensed with a written prescription and is approved for general use by the Food and Drug Administration.

Proof of Loss

Proof of Loss means written evidence acceptable to **Us** that a **Loss** has occurred.

Reasonable and Customary Charge

Reasonable and Customary Charge means the lesser of:

- 1) the usual charge made by **Covered Providers** and **Hospitals** for a given service or supply; or
- 2) the charge **We** reasonably determine to be the prevailing charge made by **Physicians** or other health care providers for a given service or supply in the geographical area where it is furnished.

Repatriation

Repatriation means the necessary arrangements for the return of an **Insured Person's** remains to an **Insured Person's** country or state of origin in the event of such **Insured Person's** loss of life.]

Scheduled Airline

Scheduled Airline means an airline which is either:

- 1) registered and certified by the Government of the United State of America to carry passengers on a regularly scheduled basis; or
- 2) registered and certified by any other governmental authority with competent jurisdiction to carry passengers on a regularly scheduled basis.

Sickness

Sickness means an illness or disease which occurs while the Policy is in-force and which results in **Medical Expenses**. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same **Sickness**. **Sickness** includes **Complications of Pregnancy**.

Spouse

Spouse means an **Insured Person's** husband or wife who is recognized as such by the laws of the jurisdiction in which the **Insured Person** resides.

War

War means:

- 1) hostilities following a formal declaration of war by a governmental authority;
- 2) in the absence of a formal declaration of war by a governmental authority, armed, open, and continuous hostilities between two (2) countries; or
- 3) armed, open, and continuous hostilities between two (2) factions, each in control of territory, or claiming jurisdiction over the geographic area of hostility.

We, Ours and Us

We, Ours and Us means Federal Insurance Company.

SECTION VI – GENERAL PROVISIONS

Beneficiary

The **Benefit Amount** for covered **Accidental** loss of life will be paid to the first surviving party in the following order:

- 1) the Insured **Person's Spouse** [or **Domestic Partner**];
- 2) in equal shares to the **Insured Person's** surviving children;
- 3) in equal shares to the **Insured Person's** surviving parents;
- 4) in equal shares to the **Insured Person's** surviving brothers and sisters;
- 5) the **Insured Person's** estate.

All other **Benefit Amounts** are paid to the **Insured Person**, unless otherwise directed by an **Insured Person** or an **Insured Person's** designee, or unless otherwise noted in this policy.

If any beneficiary has not reached the legal age of majority, then **We** will pay such beneficiary's legal guardian.

Benefit Assignment

An **Insured Person** may assign Benefit Amounts other than those for loss of life. Such assignment must be in writing, signed by the **Insured Person** and filed with the **Policyholder**. The assignment must be provided to **Us** at the time of claim or at such other time as **We** may require. **We** do not assume the responsibility for the validity of any assignment.

Certificate

When required by law, **We** will issue to the **Policyholder** for delivery to the **Insured Person** a Certificate of Insurance. The Certificate of Insurance will describe the benefits, exclusions, limitations, and conditions of this Policy and state to whom benefits are payable. Any subsequent changes to this Policy will also apply to the existing Certificates of Insurance.

Changes

This Policy can only be changed by a written endorsement that becomes a part of this Policy. The endorsement must be approved by one of **Our** officers and signed by one of **Our** authorized representatives. No agent has the authority to change this Policy or waive any of its provisions.

Compliance by Policyholder and Insured Person

We have no duty to provide insurance under this Policy unless the **Policyholder**, the **Insured Person** and the beneficiary, if applicable, have fully complied with all the terms and conditions of this Policy.

Claim Notice

Written Claim Notice must be given to **Us** or any of **Our** brokers or appointed agents within [twenty (20)] days after the date of the **Loss** or **Medical Expense** or as soon as reasonably possible. Notice must include enough information to identify the **Insured Person** and **Policyholder**. Failure to give Claim Notice within [twenty (20)] days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible.

Claim Forms

When **We** receive notice of an **Accidental** Death or Dismemberment claim, **We** will send the **Insured Person** or the **Insured Person's** designee, within [fifteen (15)] days, forms for giving **Proof of Loss** to **Us**. If the **Insured Person** or the **Insured Person's** designee does not receive the forms, then the **Insured Person** or an **Insured Person's** designee should send **Us** a written description of the **Loss**. This written description should include information detailing the occurrence, type and extent of the **Loss** for which the claim is made.

Claim Proof of Loss

Complete **Proof of Loss** must be given to **Us** within [ninety (90)] days after the date of **Loss**, or as soon as reasonably possible. Failure to give complete **Proof of Loss** within these time frames will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible, and in no event later than one (1) year after the deadline to submit complete **Proof of Loss**, except in cases where the claimant lacks legal capacity.

Claim Payment

Within [thirty (30)] days following receipt of the Claim Notice or complete **Proof of Loss**, **We** will either (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing.

Claim and Suit Cooperation

In the event of a claim under this Policy, the **Policyholder**, the **Insured Person** or the beneficiary, if applicable, must fully cooperate with **Us** in **Our** handling of the claim, including, but not limited to, the timely submission of all medical and other reports, and full cooperation with all physical examinations and autopsies that **We** may require. If **We** are sued in connection with a claim under this Policy, then the **Policyholder**, the **Insured Person** or the beneficiary must fully cooperate with **Us** in the handling of such suit. The **Policyholder**, the **Insured Person** or the beneficiary must not, except at their own expense, voluntarily make any payment or assume any obligation in connection with any suit without **Our** prior written consent.

[Coordination of Benefits

This Coordination of Benefits (“COB”) provision applies to **This Plan** when an **Insured Person** has health care coverage under more than one **Plan**. For the purposed of this COB provision, the following definitions apply:

- 1) **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more **Plans** covering the person for whom the claim is made.

The difference between the cost of a private **Hospital** room and the cost of a semi-private **Hospital** room is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is necessary either in terms of generally accepted medical practice or as specifically defined in the **Plan**.

When a **Plan** provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an **Allowable Expense** and a benefit paid.

- 2) **Claim Determination Period** means a calendar year. However, it does not include any part of a year during which a person has no coverage under **This Plan** or any part of a year before the date this COB provision or a similar provision takes effect.
- 3) **Plan** means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
 - (A) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (B) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under **Medicaid** (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (i) or (ii) is a separate **Plan**. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate **Plan**.

- 4) **Primary Plan/Secondary Plan**. The order of benefit determination rules state whether **This Plan** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person.

When **This Plan** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When **This Plan** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When there are more than two **Plans** covering the person, **This Plan** may be a **Primary Plan** as to one or more other **Plans** and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

- 5) **This Plan** means the part of the group contract that provides benefits for health care expenses.

If this COB provision applies, the order of benefit determination rules will be looked at first. The rules determine whether the benefits of **This Plan** are determined before or after those of another **Plan**. The benefits of **This Plan**:

- 1) will not be reduced when, under the order of benefit determination rules, **This Plan** determines its benefits before another **Plan**; but
- 2) may be reduced when, under the order of benefit determination rules, another **Plan** determines its benefits first.

Order of Benefit Determination Rules

- 1) General: When there is a basis for a claim under **This Plan** and another **Plan**, **This Plan** is a **Secondary Plan** which has its benefits determined after those of the other **Plan**, unless:

- (A) the other **Plan** has rules coordinating its benefits with those of **This Plan**; and
- (B) both those rules and **This Plan's** rules described below require that **This Plan's** benefits be determined before those of the other **Plan**.

- 2) Rules: This plan determines its order of benefits using the first of the following rules:

- (A) **Non-dependent/Dependent:** The benefits of the **Plan** which covers the person as an employee, member or subscriber are determined before those of the **Plan** which covers the person as a dependent of an employee, member or subscriber.
- (B) **Dependent Child/Parents Not Separated or Divorced:** Except as stated below, when **This Plan** and another **Plan** cover the same child as a dependent of different persons, called "parents":
 - (i) the benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year are determined before those of the **Plan** of the parent whose birthday falls later in that calendar year; but
 - (ii) if both parents have the same birthday, the benefits of the **Plan** which covered the parent longer are determined before those of the **Plan** which covered the other parent for a shorter period of time.

However, if the other **Plan** does not have this rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the **Plans** do not agree on the order of benefits, the rule in the other **Plan** will determine the order of benefits.

- (C) **Dependent Child/Separated or Divorced Parents:** If two or more **Plans** cover a person as a **Dependent Child** of divorced or separated parents, benefits for the child are determined in this order:

- (i) first, the **Plan** of the parent with custody of the child;
- (ii) then, the **Plan** of the **Spouse** of the parent with the custody of the child; and
- (iii) finally, the **Plan** of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents will be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' **Plans** have actual knowledge of those terms, benefits for the dependent child will be determined according to the rules above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the

benefits of the **Plan** of that parent has actual knowledge of those terms, the benefits of that **Plan** are determined first. This paragraph does not apply with respect to any **Claim Determination Period** or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- (D) Active/Inactive Employee: The benefits of a **Plan** which covers a person as an employee who is neither laid off nor retired or as that employee's **Dependent** are determined before those of a **Plan** which covers that person as a laid off or retired employee or as that employee's **Dependent**. If the other **Plan** does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (E) Continuation Coverage:
 - (i) If a person has continuation coverage under federal or state law and is also covered under another **Plan**, the following will determine the order of benefits:
 - (a) First, the benefits of a **Plan** covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.
 - (b) Second, the benefits under the continuation coverage.
 - (ii) If the other plan does not have the rule, and if, as a result, the plans do not agree on the order of benefits, this is ignored.
- (F) Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the **Plan** which covered an employee, member or subscriber longer are determined before those of the **Plan** which covered that person for the shorter time.

Effect on the Benefits of This Plan

- 1) When This Section Applies: This Section applies when, in accordance with the Order of Benefit Determination Rules, **This Plan** is a **Secondary Plan** as to one or more other **Plans**. In that event the benefits of **This Plan** may be reduced under this section. Such other **Plan** or **Plans** are referred to as the other **Plans**.
- 2) Reduction in **This Plan's** Benefits: The benefits of **This Plan** will be reduced when the sum of the following exceeds the **Allowable Expenses** in a **Claim Determination Period**:
 - (A) the benefits that would be payable for the **Allowable Expenses** under **This Plan** in the absence of this COB provision; and
 - (B) the benefits that would be payable for the **Allowable Expenses** under the other **Plans**, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of **This Plan** will be reduced so that they and the benefits payable under the other **Plans** do not total more than those **Allowable Expenses**.

When the benefits of **This Plan** are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of **This Plan**.

Right to Receive and Release Needed Information

We have the right to decide the facts We needs to apply these COB rules. We may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under **This Plan** must give the Us any facts We need to pay the claim.

Facility of Payment

A payment made under another **Plan** may include an amount which should have been paid under **This Plan**. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under **This Plan**. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, We may recover the excess from one or more of:

- 1) the persons it has paid or for whom it has paid;
- 2) insurance companies; or
- 3) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.]

Entire Contract and Application

This Policy, the **Policyholder's** application and the **Insured Person's** application, if any, together with the endorsements attached to this Policy, constitute the entire contract of insurance. If an application is completed by the **Policyholder** or **Insured Person** in connection with this Policy, then **We** will attach the application to the Policy when the Policy is issued.

Examination Under Oath

We have a right to examine under oath, as often as **We** may reasonably require, an **Insured Person**, the **Policyholder** or the beneficiary. **We** may also require the **Insured Person**, the **Policyholder** or the beneficiary to provide a signed description of the circumstances surrounding the **Loss, Accident** or **Sickness** and their interest in the **Loss, Accident** or **Sickness**. An **Insured Person**, the **Policyholder** and the beneficiary will also produce all records and documents requested by **Us** and will permit **Us** to make copies of such records or documents.

Governing Jurisdiction and Conformance With Statutes

This Policy is governed by the laws of the jurisdiction in which it is delivered to the **Policyholder**. Any terms of this Policy which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which this Policy is delivered are amended to conform to such statutes, laws or regulations.

Grace Period

The **Policyholder** is entitled to a grace period of thirty-one (31) days from the premium due date for the payment of premium due. This policy will continue in force during the grace period. The grace period does not apply to the first premium payable during this policy term. Failure to pay the first premium on or before the due date will immediately terminate this policy as of inception. **We** are not required to provide notification of such termination.

Inadvertent Error

The insurance provided under this Policy will not be prejudiced by the failure on the part of the **Policyholder** to transmit reports, collect and remit premium or comply with any of the terms and conditions of this Policy when such failure is due to an inadvertent error or clerical mistake, provided that such inadvertent error or clerical mistake is corrected promptly upon discovery.

An inadvertent error or clerical mistake by **Us** or by the **Policyholder** may be corrected upon discovery with notice by the **Policyholder** to **Us** or by **Us** to the **Policyholder**.

Informational and Advertising Material

The **Policyholder** and its representatives must gain **Our** prior written approval of all material used for advertising and solicitation relating to this Policy, regardless of the medium in which such material appears. **We** will not be responsible for any increase in payment or any changes in insurance resulting from such materials that have not been approved by **Us**.

Legal Action Against Us

No legal action may be brought to recover on this Policy until sixty (60) days after **We** have been given complete **Proof of Loss**. No such action may be brought after three (3) years from the time complete **Proof of Loss** is required to be given. No such action may be brought unless there has been full compliance with all of the terms of this Policy.

In no case will **We** be liable for benefits that are not payable under the terms of this Policy or that exceed the applicable Benefit Amounts or limits of insurance of this Policy.

Non-Renewal

This Policy is a non-renewable one year term policy. The Policy is issued for the Policy Period stated in the Insuring Agreement. If the **Policyholder** desires to continue coverage beyond the Policy Period stated, then **We** will issue a new Policy for the new Policy Period.

Physical Examination and Autopsy

We have the right to have an **Insured Person** examined by a **Physician** approved by **Us**, as often as reasonably necessary while a claim is open. **We** may also have an autopsy done by a **Physician**, unless prohibited by law. Any examinations or autopsies that **We** require will be done at **Our** expense.

Premium Payment

The **Policyholder** will collect and remit to **Us** all premium due under this Policy, subject to the grace period.

Premium is adjustable. The earned premium is calculated for each reporting period based on the applicable rates and exposures. The **Policyholder** must keep records of the information **We** need to calculate the premium and send **Us** copies of these records for each reporting period.

The earned premium will be computed on a [pro-rata] basis. Any unearned premium will be remitted to the **Policyholder** as soon as practicable.

Records and Audit

We may examine the **Policyholder's** books and records relating to this Policy at any reasonable time during the Policy term and up to three (3) years after expiration of this Policy or until final adjustment and settlement of all claims under this Policy, whichever is later.

The **Policyholder** must maintain information pertaining to **Insured Persons** including but not limited to each **Insured Person's** Benefit Amount and enrollment form, if any, and beneficiary designations or assignments.

Statements by Policyholder or Insured Person and Incontestability

We will not use any statements made by the **Policyholder** or the **Insured Person** to void the insurance or reduce benefits payable under this Policy, or to otherwise contest the validity of this Policy, unless such statements are contained in a written document signed by the **Policyholder** or the **Insured Person**. If **We** rely on such statements for this purpose, then **We** will provide a copy of the written document to the **Policyholder**, the **Insured Person** or the **Insured Person's** designee or beneficiary, as appropriate.

We will consider all statements made by the **Policyholder** and the **Insured Person** to be representations and not warranties.

We will not use statements made by the **Policyholder** or the **Insured Person** regarding insurability to contest the validity of this Policy when the statements are made more than two (2) years after this Policy has been in force during the **Insured Person's** lifetime.

Nothing in this section will preclude **Us** from asserting at any time defenses based upon a claimant's ineligibility for insurance under this Policy or upon any other Policy provision or condition.

Titles of Paragraphs

The titles of the various paragraphs of this Policy and any endorsements attached to this Policy are inserted solely for convenience of reference and do not limit or affect in any way the provisions to which they relate.

Utilization Review

There is no utilization review performed on this policy.

Workers' Compensation

The benefits payable under this Policy are not in lieu of and do not affect any requirement for workers' compensation insurance.

Student Accident & Sickness Insurance

[Insert College Name and/or logo]

Designed for the Students of
[ABC University]

[2010-2011]

Federal Insurance Company

Policy Number: [1234-56-78]

Effective [August 31, 2010 through August 30, 2011]

Important Notice

This brochure provides a general summary of the Insurance. The policy on file at the [University] contains all of the provisions, exclusions and qualifications of your insurance benefits, some of which may not be detailed in this brochure. If any discrepancy exists between the brochure and the policy, the policy will govern and control the payment of benefits.

Nondiscriminatory

Student Accident & Sickness insurance is provided to insured persons on a nondiscriminatory basis, including benefits mandated by state and federal law.

ELIGIBILITY

To be eligible for this insurance, you must be a [full-time] [or] [part-time] [or] [graduate] student as defined by the school.

[If you are a student eligible for this insurance, you are automatically insured through the Basic Plan. You may also enroll for coverage in the Supplemental Plan by completing an enrollment form within the first 31 days of the start of the semester (the "open enrollment" period).]

An eligible student may also elect coverage for his or her spouse, domestic partner and dependent children (see "Dependent Coverage" section of this brochure for more details).

[PREFERRED PROVIDER NETWORK

By enrolling in this Policy, you have the [PHCS Preferred Provider Network [, except in the western Massachusetts counties of Berkshire, Hampshire, Hampden and Franklin where the CHP Preferred Provider Network is available]]. **The Policy does not require you to use a Preferred Provider**, but if a medical expense is incurred through a Preferred Provider, the Policy will pay:

- For covered Doctor's office visits, including Licensed Mental Health Professionals, [100%] of the fees after payment of a [\$10] co-payment.
- For covered medical treatments other than Doctor's office visits, [80%] of the discounted fee, meaning that your [20%] share of the fee is also discounted.

If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

The availability of specific providers is subject to change without notice. For a complete listing of [PHCS] Preferred Providers, call [PHCS at 1-800------] for assistance or visit the [PHCS website at www.phcs.com].]

POLICY TERM

The Policy becomes effective at 12:01 A.M. standard time on [8/31/2010]. [You are automatically covered under the Basic plan effective [8/31/2010]. If you enroll in the Supplemental Plan prior to the end of the fall semester open enrollment period, your effective date of coverage is 12:01 A.M. standard time on [8/31/2010]. If you enroll after [8/31/2010] but before the end of the spring semester open enrollment period, your effective date of coverage is [1/5/2011].

TERMINATION OF COVERAGE

Your coverage will terminate at 12:01 a.m. on the earliest to occur of:

- the termination date of the Policy;
- the expiration of the period for which required premium has been paid;

- the date on which you no longer meet the eligibility criteria as an insured person;
- the date on which you enter the armed forces of any country.

EXTENSION OF BENEFITS AFTER TERMINATION

If you graduate or are granted a leave of absence by the school before the end of the semester for which you are enrolled, and you are receiving treatment for an Accidental Bodily Injury or Sickness that occurred while you were enrolled at the school, insurance will continue for [fifty-two weeks] from the date of the Accidental Bodily Injury or Sickness.

STUDENT PREMIUM

[The premium for the [Basic] insurance plan is paid for by your school.] [The premium for the [Supplemental] insurance plan is due and payable as part of your tuition and fees. If you enroll for the [Supplemental] plan after the start of the semester and before the end of the open enrollment period, premium is due at the time of your enrollment. Premium for student coverage for the [Supplemental] plan is [\$1,050] for the fall semester and [\$1,250] for the spring semester and summer.]

REFUND OF PREMIUM

Except for medical withdrawal due to a covered Accident of Sickness, if you withdraw from school for any reason during the first 31 days after the date for which coverage is purchased you will not be insured under the policy and a full refund of the premium will be made. If you withdraw after the first 31 days you will remain insured under the policy for the full period for which premium has been paid and no refund of premium will be made.

If you enter the armed forces of any country, you will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made upon written request to the insurance company [within ninety (90) days of entry into the armed forces].

DEPENDENT COVERAGE

If you are covered under the Policy insurance may be purchased for your eligible Dependents. Your Dependents will be covered for the same benefits for which you are covered. Dependent coverage begins and ends with your coverage.

Coverage for a newborn child will begin automatically from the moment of birth and continue for 90 days. Written notice of the birth along with the required premium must be furnished within 90 days of the date of birth in order to continue coverage beyond such 90 day period.

Coverage for an adopted child will begin on the date of: the placement by a licensed placement agency of the child for purposes of adoption in your home. Payment of

The required premium for your adopted children must be furnished within 31 days of the petition date or placement date in order to continue coverage beyond such 31 day period.

Coverage for a Spouse or Domestic Partner will begin on your date of marriage or civil union. Payment of the required premium for the Spouse or Domestic Partner must be furnished within 31 days after the date of marriage or civil union in order to continue coverage beyond such 31 day period.

INSURANCE COVERAGE

Your insurance is made up of the following coverages:

1. Medical Benefits
2. Accidental Death & Dismemberment Benefit
3. Prescription Drug Benefit [
4. Medical Evacuation & Repatriation Benefit]

MEDICAL BENEFITS

[The policy will pay [80%] of the eligible Medical Expenses incurred up to [\$50,000] per Sickness or Accidental Bodily Injury if you use a Preferred Provider. The policy will pay [60%] of the Reasonable and Customary Charge if you use a non-preferred provider. The benefit amount may be subject to a deductible or Co-Payment. Medical Expenses include:]

[The policy will pay the Reasonable and Customary Charge for eligible Medical Expenses incurred up to [\$50,000] per Sickness or Accidental Bodily Injury. The benefit amount may be subject to a deductible or co-payment. Medical Expenses include:]

[The policy will pay the amounts shown below for eligible Medical Expenses incurred up to [\$50,000] per Sickness or Accidental Bodily Injury. The benefit amount may be subject to a deductible or co-payment. Medical Expenses include:]

Hospital Room and Board is covered up to [[60% of] the semi-private room rate or intensive care unit room rate. [[80%] will be paid if a Preferred Provider is used.]

[\$250] per day.]

Miscellaneous hospital Expenses are covered up to [[60% of] the Reasonable and Customary Charge. [[80%] will be paid if a Preferred Provider is used.]

[\$250] per day.]

Physician's Treatment Expense (for treatment by a physician while hospital confined) is covered up to [[60% of] the Reasonable and Customary Charge. [[80%] will be paid if a Preferred Provider is used.]

Surgery Expense (for inpatient or outpatient surgery) is covered up to [[60% of] the Reasonable and Customary Charge. [[80%] will be paid if a Preferred Provider is used.]

Assistant Surgeon Fee (if an assistant surgeon is required by the hospital or the procedure) is covered up to [30%] of the amount paid to the surgeon.

Anesthesiologist Fee (for the services of an anesthesiologist who is not employed or retained by the hospital in which the surgery is performed) is covered up to [30%] of the amount paid to the surgeon.

Second Surgical Opinion Consultation Expense (when conducted by a board certified specialist in the medical field relating to the surgical procedure recommended) is covered up to [5%] of the amount paid to the surgeon.

Ambulance Service Expense pays up to the maximum allowable rate established by the Connecticut Department of Public Health.

Dental Expenses (for the removal of impacted wisdom teeth or for treatment as the result of an Accidental Bodily Injury) are covered up to [80%] of the Reasonable and Customary Charge subject to a maximum of [\$50] per tooth for impacted wisdom teeth and a maximum of [\$500] per tooth for Accidental Bodily Injury.

Physiotherapy Treatment Expense (for services prescribed by a physician for a stated number of treatments) is covered up to the Reasonable and Customary Charge.

Outpatient Miscellaneous Expenses (for services provided in a Covered Provider's office, community mental health center, home based services for mental illness, hospital or outpatient department or emergency room, clinical lab, radiological facility or similar facility, and temporary surgical appliances and equipment) are covered up to [\$1,500] per Sickness or Accidental Bodily Injury subject to the following deductible for each visit:

- Emergency room: [\$100] if not admitted.
- Emergency room: [\$50] if ordered by a Covered Provider and not admitted.
- Outpatient department/clinic: [\$35].
- Covered Provider's office visits: [\$25].
- Covered Provider's office visits at a Preferred
- Provider: payable at 100% after an [\$8] Co-Payment

Alcohol and Drug Dependency: pays expenses incurred for the Necessary Care and Treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally. For each 24 month period this benefit will pay a minimum of \$6,000 for the Necessary Care and Treatment of alcohol or drug dependency. No more than half of the maximum benefit amount for alcohol or drug dependency for a twenty-four (24) month period shall be paid for the Necessary Care and Treatment of alcohol or drug dependency in any thirty (30) consecutive day period.

Breast Reconstruction and Mastectomy: pays expenses incurred for: 1) medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than 48 hours (unless the decision to discharge the patient before the expiration of the minimum length of stay is made by the attending physician in consultation with the insured person); 2) reconstructive surgery on each breast for which a mastectomy has been performed; 3) reconstructive surgery on a non-diseased breast to provide asymmetrical appearance; 4) prostheses; and 5) physical complications during all stages of a mastectomy, including lymphedemas.

Cancer Drugs: pays expenses incurred for drugs to treat cancer provided that: 1) such drugs have been approved for sale by the federal Food and Drug Administration; and 2) the drug is recognized as safe and effective for treatment of the specific type of cancer for which it has been prescribed in: (a) any of the following standard reference compendia: (i) The American Hospital Formulary Service Drug Information; (ii) The National Comprehensive Cancer Network Drugs and Biologics Compendium; or (iii) The Elsevier Gold Standard's Clinical Pharmacology; or b) two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature; or c) other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner.

This benefit also pays expenses incurred for the administration of the drug.

Children's Preventive Health Care Services: pays expenses incurred for physician-delivered or physician-supervised services for an insured person's child from birth through 18 years of age, with Periodic Preventive Care Visits for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Services include review of medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests. This benefit will cover 20 visits at the following intervals: 1) 6 times during the child's first year after birth; 2) 3 times during the next year; and 3) annually until age 18.

Colorectal Cancer Screening: pays expenses incurred for colorectal cancer examinations and laboratory tests for: 1) insured persons who are 50 years of age or older; 2) insured persons who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and 3) insured persons experiencing the following symptoms of colorectal cancer as determined by a physician and: a) bleeding from the rectum or blood in the stool; or b) a change in bowel habits that lasts more than 5 days.

The screening shall involve an examination of the entire colon, including the following examinations or laboratory tests, or both: 1) an annual fecal occult blood test or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years; 2) a double – contrast barium enema every 5 years; or 3) a colonoscopy every 10 years; and 4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up surgery: 1) if the initial colonoscopy is normal, follow-up is recommended in 10 years; 2) for insured persons with 1 or more neoplastic polyps or adenomatous polyps, follow-up is recommended in 3 years; 3) if single tubular adenoma of less than one centimeter (1cm) is found, follow-up is recommended in 5 years; and 4) for insured persons with large sessile adenomas greater than three centimeters (3cm), follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

Contraceptives: pays expenses incurred for prescription drugs approved by the U.S. Food and Drug Administration for use as a contraceptive.

Dental Care: pays expenses incurred for anesthesia and hospital or ambulatory surgical facility charges for services provided in conjunction with dental care that is provided to an insured person if: 1) the insured person's physician certifies that because of the insured person's age or condition, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and 2) the insured person is a child age 7 or under who is determined by 2 dentists licensed under the Arkansas Dental Practice Act, §17-82-101, et seq., to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or 3) the insured person has been diagnosed with a serious mental or physical condition; or 4) the insured person has a significant behavioral problem as determined by the insured person's physician.

Diabetes: pays expenses incurred for: a) laboratory and diagnostic tests for all types of diabetes; b) the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes; c) diabetes equipment, in accordance with the insured person's treatment plan; and d) drugs and supplies prescribed by a prescribing physician.

Diabetes Self-Management Training: pays expenses incurred for self-management training provided by an appropriately licensed health care professional who has completed an educational program in compliance with the National Standards for Diabetes Self-Management

Education Program as developed by the American Diabetes Association. Coverage is limited to 1 training program per lifetime per insured person. Additional diabetes self-management training may be provided in the event the insured person's physician prescribes additional diabetes self-management training and is needed because of a significant change in the insured person's symptoms or conditions. Diabetes self-management training shall be provided only upon prescription by the insured person's physician.

Hearing Aids: pays expenses incurred for hearing aids or hearing instruments sold by a professional licensed by the state to dispense a hearing aid or hearing instrument. The benefit is limited to [\$1,400] every 3 years.

Hospice Care: pays expenses incurred for Hospice services to a terminally ill insured person who has a life expectancy of 6 months or less. Hospice services include but are not limited to: 1) physician's services; 2) care provided by or under the supervision of a nurse; 3) social services, volunteer services and counseling services provided by professional or volunteer staff under professional supervision.

In Vitro Fertilization: pays the expenses incurred for in vitro fertilization services performed at: 1) a medical facility licensed or certified by the Department of Health; 2) a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics; or 3) a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

Mammography: pays expenses incurred for: 1) a baseline mammogram for women who are 35 to 40 years of age; and 2) a mammogram for women who are 40 to 49 years of age every 1 to 2 years based on the recommendation of the woman's physician; and 3) a mammogram every year for women who are 50 years of age or older.

Maternity and Newborns: pays expenses incurred for inpatient care for mother and newborn in a health care facility for: 1) 48 hours following a normal vaginal delivery; or 2) 96 hours following a caesarean delivery. This benefit also pays expenses incurred for newborn testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law.

Medical Food and Low Protein Modified Food Products: pays expenses incurred for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a physician for the

therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the cost of the medical food or low protein modified food products for an insured person or an insured person's dependent exceeds the income tax credit of \$2,400.00 per year per person allowed under §23-79-702.

Mental Illness: pays expenses incurred for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of those with developmental disorders. Benefits will be paid under the same terms and conditions as provided for the treatment of other medical illnesses or conditions.

[Musculoskeletal Disorders of the Face, Neck or Head: pays expenses for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and non-surgical procedures.]

Prostate Cancer Screening: pays expenses incurred for one screening per year for the early detection of prostate cancer in men 40 years of age and older according to the National Comprehensive Cancer Network guidelines. Such screening must be performed by a qualified medical professional. If a qualified medical professional recommends that an insured person undergo a prostate specific antigen blood test, this benefit will pay the expenses incurred for such test even if the insured person had a digital rectal examination and the examination result was negative. This benefit is not subject to a deductible.

Speech, Hearing and Language: pays expenses incurred for the diagnosis and treatment of loss or impairment of speech or hearing, however coverage does not apply to hearing instruments or devices.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT
Insured persons are covered for accidental loss of life, limb, sight, speech or hearing as follows:

Accidental Loss of:	Benefit Amount:
Life.....	[\$3,000]
Speech & hearing.....	[\$3,000]
Speech & one of a hand, foot or sight of an eye...	[\$3,000]
Hearing & one of a hand, foot or sight of an eye...	[\$3,000]
Both hands, both feet, sight of both eyes or a combination of any two of a hand, foot or sight of an eye.....	[\$3,000]
Hand, foot or sight of an eye.....	[\$1,500]
Speech or hearing.....	[\$1,500]
Thumb and index finger of the same hand.....	[\$750]

The benefit amount shown is payable if an accident results in a covered loss not otherwise excluded. The accident must occur while an insured person is insured under this policy, while it is in force. The covered loss must occur within [ninety (90) days] after the accident.

"Loss" means, with respect to a hand, complete severance of at least 4 fingers at or above the metacarpal phalangeal joint on the same hand or at least 3 fingers and the thumb on the same hand; with respect to a foot, complete severance through or above the ankle joint; with respect to hearing, permanent, irrecoverable and total deafness, with an auditory threshold of more than 90 decibels in each ear; with respect to sight, permanent loss of vision where the remaining vision is no better than 20/200 using a corrective aid or device; with respect to speech, the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices; with respect to thumb and index finger, the complete severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand.

PRESCRIPTION DRUG BENEFIT

Pays for covered Prescription Drugs as a result of sickness or accidental bodily injury up to [\$750]. The benefit is subject to the following co-payments:

- [\$10] per insured person per generic prescription when using the [Express Scripts card].
- [\$20] per insured person per brand name prescription when using the [Express Scripts card].
- [80%] of reasonable and customary charge when not using the [Express Scripts card].]

[MEDICAL EVACUATION & REPATRIATION BENEFIT

If an insured person's sickness or accidental bodily injury causes such insured person to be hospital confined for [5] or more days, and as a result the insured person must be medically evacuated from the local hospital where emergency medical treatment is initially given to: 1) another hospital in the insured person's country or state of origin; or 2) the insured person's permanent residence in his or her country or state of origin, then this benefit will pay the covered expenses for such medical evacuation up to [\$10,000].

If an insured person's sickness or accidental bodily injury causes his or her loss of life, then this benefit will pay up to [\$10,000] to repatriate the insured person's remains to his or her country or state of origin [\$10,000].

The medical evacuation or repatriation must be recommended by the attending physician and approved and arranged by [MEDEX Global Group]. In addition to medical evacuation and repatriation services, MEDEX will provide the following emergency assistance services in the event of a travel-related emergency:

- Worldwide medical and dental referrals.
- Monitoring of treatment.
- Continuous updates to family and home physician.
- Medical records transfer and coordination of medication, vaccine and blood Transfers.
- Legal referrals.

- Assistance in the replacement of lost or stolen travel documents.
- Translation services.
- Emergency travel arrangements.
- Facilitation of hospital payment and transfer of insurance information to medical providers.

If you have a medical or travel emergency, simply call [MEDEX] toll-free at [1-866-832-6930] or collect at [+1-410-453-6330]. Please refer to local country dialing instructions and make sure to use a telephone that has international access.

For general inquiries regarding your coverage please call [Consolidate Health Plans at 1-800-633-7867].]

EXCLUSIONS

Insurance does not apply to any loss or medical expense which results from:

1. any treatment, service or supply that is not required for the care and treatment of Accidental Bodily Injury or Sickness, or any service, treatment or supply that is not recommended by the attending Covered Provider;
2. Elective Surgery or Elective Treatment;
3. any treatment, service or supply that is Experimental or Investigational;
4. cosmetic surgery or treatments;
5. a Pre-existing Condition that results in any service, treatment or supply within the first 6 months following the insured person's effective date of coverage under the Policy unless during the period immediately preceding the insured person's effective date under the Policy, the insured person was covered under prior Creditable Coverage for at least 6 months. Creditable Coverage of less than 6 months will be credited toward satisfying this Pre-Existing Condition exclusion;
6. any treatment, service or supply that is provided normally without charge by the Policyholder's health center, infirmary or hospital, [or by any person employed by or contracted with the Policyholder [including team physicians and trainers]];
7. any treatment, service or supply that is provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
8. any treatment, service or supply which is received without charge or legal obligation to pay or would not routinely be paid in the absence of insurance;
9. any treatment, service or supply that is provided by an insured person's Immediate Family Member;

<p>10. Accidental Bodily Injury or Sickness for which benefits are payable under any Workers Compensation or Occupational Disease Law, Employers Liability Law, Public Assistance Programs or Occupational Benefit Plans;</p> <p>11. a motor vehicle Accident for which benefits are payable from other valid insurance;</p> <p>12. declared or undeclared War;</p> <p>13. Accidental Bodily Injury sustained or Sickness contracted while the insured person is participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to Reserve or National Guard active duty for training unless it extends beyond 31 days;</p> <p>14. [treatment occurring outside of the United States;]</p> <p>15. routine physical examinations, preventive testing or treatment, screening exams or testing in the absence of Sickness or Accidental Bodily Injury unless specifically covered elsewhere in the Policy;</p> <p>16. expenses for preventative medicines, vaccines, [or Prescription Drugs] unless specifically covered elsewhere in the Policy;</p> <p>17. [Prescription Drugs, services or supplies as follows: (a) therapeutic devices or appliances, including hypodermic needles or syringes prescribed by a physician for the purpose of administering medications for medical conditions, provided such medications are not covered under the Policy, support garments and other non-medical substances; (b) immunization agents, biological sera, blood or blood products administered on an outpatient basis; (c) drugs labeled Experimental or Investigational; (d) anabolic steroids used for body building; (e) drugs used to treat or cure baldness; (f) drugs used for the purpose of weight control; (g) growth hormones; (h) refills in excess of the number specified or dispensed after one year of the date of prescription;]</p> <p>18. [Off-Label Drug Use unless specifically covered elsewhere in the Policy;]</p> <p>19. dental treatment, except for treatment (a) for the removal of impacted wisdom teeth or (b) resulting from Accidental Bodily Injury to sound, natural teeth;</p> <p>20. prescriptions and examinations for, or repair and replacement of, eyeglasses or contact lenses;</p> <p>21. [hearing examinations or hearing aids or other treatment for hearing defects and problems, except for newborn hearing for the first 31 days of coverage. Hearing defects means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;]</p> <p>22. [orthopedic appliances, orthotics or other devices used for treatment of a foot or conditions relating to a</p>	<p>foot including but not limited to weak, strained or flat feet, corns, calluses, bunions, or toenails;]</p> <p>23. an insured person's commission or attempted commission of any illegal act including but not limited to any felony;</p> <p>24. [an insured person being intoxicated. Intoxication is defined by the laws of the jurisdiction where treatment is received;]</p> <p>25. [an insured person being under the influence of any narcotic or other controlled substance unless such narcotic or other controlled substance is taken and used as prescribed by a physician;]</p> <p>26. [sex changes, sexual enhancement drugs, sexual dysfunctions or inadequacies with the exception of penile prosthesis required for physiological impotence;]</p> <p>27. suicide, attempted suicide, self-inflicted injury or attempted self-inflicted injury unless covered under benefits for Mental and Nervous Conditions;]</p> <p>28. completion of forms by the Covered Provider or fees for appointments scheduled and not kept;</p> <p>29. [treatment for smoking cessation;]</p> <p>30. [addiction and co-dependency treatment, services or supplies unless specifically covered elsewhere in the Policy;]</p> <p>31. [weight management, weight reduction, nutrition programs, treatment for obesity, or surgery for removal of excess skin or fat;]</p> <p>32. [[over-the-counter medication or Durable Medical Equipment unless specifically covered elsewhere in the Policy;]</p> <p>33. membership fees to a spa or health club, fitness training or exercise equipment;</p> <p>34. rest cures, custodial care or non-medical care;]</p> <p>35. [maintenance therapy which is defined as those therapy services rendered to an insured person who is no longer making documentable progress to maintain the level of progress previously attained;]</p> <p>36. [an insured person's participation in intercollegiate or professional sports, including practice, conditioning, play and travel;]</p> <p>37. [an insured person riding as a passenger in, entering or exiting any aircraft, except as a fare-paying passenger in an aircraft owned or operated by a Scheduled Airline;]</p> <p>38. [a motor vehicle Accident if the insured person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place [, except in a Driver's Education Program]. [This exclusion will not apply to passengers if they are insured persons under this Policy;]</p> <p>39. [Accidental Bodily Injury resulting from travel in or</p>
<p>Form No. SH-7000-AR 11</p>	<p>Form No. SH-7000-AR 12</p>

upon a snowmobile, ATV (all terrain or similar type two or three wheeled vehicle [and/or off-road four-wheeled motorized vehicles]), [personal water craft or bungee jumping;]

- 40. the insured person engaging in or participating in a motorized vehicular race or speed contest including training or practice;
- 41. the insured person engaging in or participating in scuba diving to depths of more than 100 feet; skydiving; hang-gliding or para-gliding; parascending other than over water; bungee jumping; mountaineering or rock climbing normally requiring the use of guides or ropes; or caving;
- 42. [injury resulting from fighting, except in self-defense.]

With respect to Accidental Death & Dismemberment Benefit only, the following exclusion also applies:

Insurance does not apply to any Accident, Accidental Bodily Injury or Loss caused by or resulting from the insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an Accident or Accidental consumption of a substance contaminated by bacteria.

DEFINITIONS

Accident or Accidental means a sudden, unforeseen, and unexpected event which: 1) happens by chance; 2) is independent of illness, disease or other bodily malfunction or medical or surgical treatment thereof; 3) occurs while the insured person is insured under this Policy which is in force; and 4) is the direct cause of loss .

Accidental Bodily Injury means bodily injury, which: 1) is Accidental; 2) is the direct cause of a loss; and 3) occurs while an insured person is insured under this Policy, which is in force.

Complications of Pregnancy means: (1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and (2) nonelective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy does not include: (1) false labor; (2) occasional spotting; (3) physician prescribed rest during the period of pregnancy; (4) morning Sickness; (5) hyperemesis gravidarum; (6) pre-eclampsia; or (7) similar conditions associated with the management of a difficult pregnancy but which are not distinctly related to the pregnancy.

Co-Payment means the charge payable by the insured person for certain Medical Expenses.

Covered Provider means a: (1) physician; (2) Licensed Mental Health Professional; (3) psychotherapist; (4) chiropractor licensed by the Commonwealth; (5) physical therapist; (6) dentist while providing oral surgical care, services, procedures or benefits covered by this policy; (7) podiatrist; (8) optometrist while providing visual services which are covered by this policy; (9) certified nurse midwife while acting within the lawful scope of practice for a certified nurse midwife; (10) certified registered nurse anesthetist or nurse practitioner designated as such by the board of registration in nursing while providing services that are within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice; 11) physician assistant performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioner. Covered Provider does not include an insured person or an Immediate Family Member of an insured person.

Creditable Coverage means insurance under any of the following health plans with no lapse in coverage of more than sixty-three (63) days during the period immediately preceding the insured person's effective date under this Policy: (1) a group health plan; (2) a health plan, including but not limited, to a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program; (3) Part A or Part B of Title XVIII of the Social Security Act, as amended; (4) Title XIX of the Social Security Act, as amended, other than coverage consisting solely of benefits under section 1928; (5) 10 U.S.C. chapter 55, as amended; (6) a medical care program of the Indian Health Service or of a tribal organization; (7) a state health benefits risk pool; (8) a health plan offered under 5 U.S.C. chapter 89, as amended; (9) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701 (c)(1)(I), as amended by Public Law 104-191; or (10) a health benefit plan under the Peace Corps Acts, 22 U.S.C. 2504(e), as amended; or (11) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

Creditable Coverage includes continuation or conversion coverage but does not include Accident-only, credit, coverage for on-site medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Dependent Child means your unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of the filing of a petition of adoption if the application for coverage is within 60 days of the filing of the petition Coverage shall begin at the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth . The Dependent Child must be primarily dependent upon you for maintenance and support and must be: (1) under the age of [19]; (2) under the age of [25] if enrolled as a full-time student at an Institution of Higher Learning; or (3) classified as an Incapacitated Dependent Child.

Elective Surgery or Elective Treatment means any surgery or treatment that: (1) is not necessitated by a pathological or traumatic change in the function or structure of any part of the body; (2) is for the insured person's convenience; and (3) does not require immediate attention.

Experimental or Investigational means any drug, device or medical treatment (collectively "Technology") that satisfies any of the following criteria: (1) the Technology cannot be lawfully marketed within the United States without the approval of the U.S. FDA and the U.S. FDA has given no approval to market the Technology at the time the Technology is furnished; (2) the Technology for the particular diagnosis or set of indications is: (a) the subject of ongoing Phase I or II clinical trials; or (b) the investigational arm of a Phase III study or under study to determine its: (i) maximum tolerated dosage; (ii) efficacy; (iii) safety; or (iv) toxicity compared with the standard means of treatment or diagnosis; (3) as demonstrated by Medical Evidence, expert opinion regarding the Technology has formed a consensus that further studies or clinical trials are necessary to determine the Technology's: (a) maximum tolerated dosage; (b) efficacy; (c) safety, or (d) toxicity compared with the standard means of treatment or diagnosis; (4) the Technology was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval. Any treatment that results from an Experimental or Investigational Technology will also be considered Experimental or Investigational.

Hospice means a centrally coordinated program ensuring continuity and consistency of home and inpatient care provided directly through an inpatient facility operating under its hospice license or through an agreement.

Hospital means a public or private institution which: (1) is licensed in accordance with the laws of the jurisdiction where it is located; (2) is accredited by the Joint Commission on Accreditation of Hospitals; (3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients; (4) provides organized facilities for diagnosis and medical or surgical treatment; (5) provides 24 hour nursing care; (6) has a Physician or staff of Physicians ; and (7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a

Hospital Confined or hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a hospital.

Incapacitated Dependent Child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on an insured person for support and maintenance. The incapacity must have occurred while the child was: 1) under the age of [19]; or 2) under the age of [25] if enrolled as a full-time student at an Institution of Higher Learning.

Licensed Mental Health Professional means a: (1) physician who specializes in the practice of psychiatry; (2) licensed psychologist; (3) licensed independent clinical social worker; (4) licensed mental health counselor; or (5) licensed nurse mental health clinical specialist.

Medical Expenses means the Reasonable and Customary Charges for any medical treatment, service or supply given by a Covered Provider that is: (1) not in excess of the maximum amount payable for services as specified in the Schedule of Benefits; (2) not in excess of the charges that would have been made in the absence of this insurance; (3) incurred while this Plan is in force as to the insured person; and (4) in excess of any deductible amount.

Necessary Care and Treatment means treatment, including detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, in an alcohol or drug dependency treatment facility or care and treatment in a hospital.

[Off-Label Drug Use means the use of a drug for the purpose other than that for which it was approved by the U.S. Food and Drug Administration (FDA). Off-Label Drug Use does not mean a drug: 1) that has been approved by the FDA at the time the drug is furnished; and 2) which is necessary for the prescribed indication; and 3) which is supported by adequate medical and scientific evidence as being safe and effective for the prescribed indication, as noted in the Centers for Medicare & Medicaid Services approved compendia, or in a well-recognized major peer reviewed medical journal, or in the published results of a clinical trial presenting data that supports the use as safe and effective.]

Physician means a licensed practitioner of the healing arts, acting within the scope of his or her license to the extent provided by the laws of the jurisdiction in which medical treatment is provided. Physician does not include an insured person, or an Immediate Family Member of an insured person.

Pre-Existing Condition means a Sickness or Accidental Bodily Injury which, during the six (6) month period prior to the insured person's effective date of coverage under the Policy, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical

place for the treatment of alcoholics or drug addicts.

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advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received or as to a pregnancy existing on the effective date of coverage. Pre-Existing Condition does not include pregnancy.

Preferred Provider means the Covered Providers and hospitals who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are: [NEHCA HMO-PP0 hospitals and physicians].

Reasonable and Customary Charge means the lesser of: (1) the usual charge made by Covered Providers or hospitals for a given service or supply; or (2) the charge that the insurance company reasonably determines to be the prevailing charge made by Covered Providers or hospitals for a given service or supply in the geographical area where it is furnished.

Sickness means an illness or disease which occurs while the Policy is in-force and which results in Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. Sickness includes Complications of Pregnancy.

CONFORMANCE WITH STATE STATUTES

Any terms of the policy which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which the policy is delivered are amended to conform to such statutes, laws or regulations.

CLAIM PROCEDURES

In the event of a covered Accident or Sickness:

1. Contact your student health services if available. If student health services is not available, determine whether a [PHCS] Preferred Provider is located nearby for treatment at a reduced cost to you. **IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.**
2. Written Claim Notice must be given within 20 days after the date of the Loss or Medical Expense or as soon as reasonably possible. Failure to give Claim Notice within 20 days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible.
3. Itemized billings should be submitted by you or your health care provider within 90 days of treatment, or as soon as reasonably possible. All claim forms should be submitted to the Claim Administrator shown below.

HEALTH SPECIAL RISK, INC.

2077 Roosevelt Avenue
P.O. Box 118098
Carrollton, TX 75011-8098
Medical Providers Call: (800) 785-2446
All Other Calls: (888) 308-7320
Email: Claims@hsri.com

Within 45 days following receipt of the Claim Notice or complete Proof of Loss, We will either: (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If We fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the complete Proof of Loss, at the rate of 1.5% per month not to exceed 18% per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on this policy.

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Health Special Risk's Appeal Department at the above address. Include your name, phone number, address, school attended and email address, if available. Claims will be reviewed and responded to within 60 days.

For a copy of the Company's privacy notice, call, write, or log on to:

Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
(817) 479-2100
www.AHPCare.com/etbu

The insurance is underwritten by:
Federal Insurance Company, a member insurer
of the Chubb Group of Insurance Companies
Policy No. [1234-56-78]

SERFF Tracking Number: CHUB-126227681 State: Arkansas
 Filing Company: Federal Insurance Company State Tracking Number: 43656
 Company Tracking Number: 09-AP-9-F
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Student
 Project Name/Number: Student/09-Ap-9-F

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attached is our Statement of Readability as required. Attachment: AR student health cert of readability.pdf	Approved-Closed	10/05/2009

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: There is no application for this filing. Comments:	Approved-Closed	10/05/2009



Certificate of Readability

Name of Company: **FEDERAL INSURANCE COMPANY, NAIC #20281**

This is to certify that the forms listed on the attached page(s) have attained the minimum readability score.

OPTION SELECTED

- Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is 59.55.
- Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

TEST OPTION SELECTED

- Test was applied to entire policy form(s).
- Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

STANDARD FOR CERTIFICATION

A checked block indicates the standard has been achieved.

- The policy text achieves a minimum score of 59.55 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
- The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- The section titles are captioned in bold face type or otherwise stand out, significantly from the text.
- Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

The table of contents or an index of the principle sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than three (3) pages.)

Michael Feighan

Date: 9/30/2009

Michael Feighan
Vice President
Chubb & Son, a division of Federal Insurance Company

SERFF Tracking Number: CHUB-126227681 *State:* Arkansas
Filing Company: Federal Insurance Company *State Tracking Number:* 43656
Company Tracking Number: 09-AP-9-F
TOI: H04 Health - Blanket Accident/Sickness *Sub-TOI:* H04.001 Student
Product Name: Student
Project Name/Number: Student/09-AP-9-F

Superseded Schedule Items

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.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/01/2009	Form	Policy	10/05/2009	AR Student Health policy (Final).pdf (Superseded)



STUDENT ACCIDENT & SICKNESS
INSURANCE POLICY

Issued by
Federal Insurance Company

FOR

[POLICYHOLDER]

[Producer: XYZ, Inc.]
[123 Any Street]
[Any town, Any State]
[Attn: John Smith]

Chubb Underwriting Office: Federal Insurance Company
[15 Mountain View Road]
[P O BOX 1615]
[Warren, New Jersey 07061-1615]

*Words and phrases that appear in **bold** print have special meanings and are defined in the Definitions section(s) of this Policy. Defined terms include the plural.*

*Throughout this Policy the words "**We**", "**Us**" and "**Our**" refer to the **Company** providing this insurance.*

Please Read This Policy Carefully

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Insuring Agreement

*Chubb Group of Insurance Companies
15 Mountain View Road, P.O. Box 1615
Warren, New Jersey 07061-1615*

Policyholder's Name and Address:

[University of ABC.]
[123 Main Street]
[PO Box 123245
[Town, State, USA]

Policy Number: [1234-56 - 7890]
Effective Date: [09 - 01 - 2009]
Anniversary Date: [September 1]

*Issued by the stock insurance company
indicated below:*

FEDERAL INSURANCE COMPANY
Incorporated under the laws of
INDIANA

Policy Period

From: [09 - 01 -2009] To: [09-01-2010]
12:01 A.M. standard time at the **Policyholder's** address shown in this Insuring Agreement.

This insurance is provided by the **Company** in consideration of payment of the required premium.

The insurance under this Policy begins on the Effective Date shown above and ends on the last day of the Policy Period shown.

The **Policyholder's** acceptance of this Policy terminates any prior Policy of the same Policy number, effective with the inception of this Policy.

Company

The **Company** issuing this Policy has caused this Policy to be signed by its authorized officers, but this Policy will not be valid unless also signed by a duly authorized representative of the **Company**.

FEDERAL INSURANCE COMPANY (Incorporated under the laws of Indiana)

President

Secretary

Authorized Representative

[Countersigned by :

Licensed Resident Agent]

Premium Summary

Section I - Premium Due Date

[09 -01 - 2009]

Section II - Premium Payment

The **Policyholder** shown in Section I of the Insuring Agreement is responsible for the collection and remittance of all required premiums. Premiums are calculated and payable as follows:

Amount Due:	[Basic and Major Medical Plans]	[Supplemental Plan]
	[\$250] per student for the Fall Semester]	[\$1,050] per student for the Fall Semester]
	[\$300] per student for the Spring Semester and Summer]	[\$1,250] per student for the Spring Semester and Summer]

Schedule of Benefits

*Chubb Group of Insurance Companies
15 Mountain View Road, P.O. Box 1615
Warren, New Jersey 07061-1615*

Policyholder's Name:
[University of ABC.]

*Issued by the stock insurance company
indicated below:*

FEDERAL INSURANCE COMPANY
Incorporated under the laws of
INDIANA

[Section I – Insured Persons

The following are the **Insured Persons** under this Policy:

<u>Class</u>	<u>Description</u>
[1]	[All [Full-Time] [and] [Part-Time] Students of the Policyholder [, including Graduate Students] [and] [International Students]] and their Dependents]

Section II – Medical Benefits

[Class 1] Maximum Benefit Amount per Sickness or Accidental Bodily Injury : [\$50,000] [Basic Plan: [\$3,000]] [Major Medical Plan: [\$50,000]] [Supplemental Plan: [\$250,000]]	
[Deductible:	[\$50] per Insured Person per Sickness or Accidental Bodily Injury unless shown differently in the table below or in the State Mandated Benefits section of the policy. The annual maximum deductible payable by an Insured Person will not exceed [\$250.] [There is no deductible for services provided at the Student Health Center.]
[Co-Payment:	[\$10] per Covered Provider office visit.] [There is no Co-Payment for services provided at the Student Health Center.]
[Insured Percent:	[80%] unless shown differently in the table below.] [[100%] for the Basic Plan unless shown differently in the table below.] [[80%] for the Major Medical Plan unless shown differently in the table below.] [[100%] for the Supplemental Plan unless shown differently in the table below.]
[The Pre-Existing Condition exclusion is waived if treatment is provided at the Student Health Center.]	

INPATIENT SERVICES:	Preferred Provider	Out of Network
<p>[Hospital Room & Board while Hospital Confined [subject to the daily semi-private room rate including general nursing care provided by the Hospital.] [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] semi-private room rate or Intensive Care Unit room rate] [[80% of] Preferred Allowance [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>	<p>[[60% of] semi-private room rate or Intensive Care Unit room rate] [[60% of] Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>
<p>[Miscellaneous Hospital expenses incurred while Hospital Confined including the cost of the [operating room,] [intensive care,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] Preferred Allowance [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>	<p>[[60% of] Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day][up to a maximum of [20] days]</p>
<p>[Hospital expense while Hospital Confined including the cost of the [operating room,] [intensive care,] [room and board,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80%] of Preferred Allowance [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day] [up to a maximum of [20]days]</p>	<p>[60%] of Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day] [up to a maximum of [20]days]</p>
<p>In-Hospital Physician expense. [Does not include expenses for [Surgeon,] [Assistant Surgeon,] [Anesthesiologist] [or] [Second Surgical Opinion.]]</p>	<p>[80% of] Preferred Allowance [\$250 per day] [up to a maximum of [20]days]</p>	<p>[60% of] Reasonable and Customary Charge [\$250 per day] [up to a maximum of [20]days]</p>
<p>Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]</p>	<p>[[80% of] Preferred Allowance] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>	<p>[[60% of] Reasonable and Customary Charge] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>
<p>Assistant Surgeon's fees for services of an assistant surgeon required by the Hospital or by the procedure.</p>	<p>[30%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network) [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>	
<p>Anesthesiologist's fees for services of an anesthesiologist who is not employed or retained by the Hospital in which the surgery is performed.</p>	<p>[30%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network) [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury.]</p>	

[Registered Nurse Expense for private nursing care]	[[80% of] Preferred Allowance][subject to a maximum of [\$50] per day]] [\$50 per day] [up to a maximum of [20]days]	[[60% of] Reasonable and Customary Charge][subject to a maximum of [\$50] per day]] [\$50 per day] [up to a maximum of [20]days]
[Second Surgical Opinion][or] [Physician Consultation Expense] when a necessary surgical procedure is recommended; conducted by a board certified specialist in the medical field relating to the surgical procedure recommended. This includes x-rays and diagnostic tests.]	[15%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network)	
[Preadmission testing]	[[80%] of Preferred Allowance]	[[60%] of Reasonable and Customary Charge]
[Mental and Nervous Disorder Expenses]	[[80%] of Preferred Allowance to a maximum of [\$400] per day and [\$10,000] per policy term unless shown differently in the Mandate section of the contract.]	[[60%] of Reasonable and Customary Charge to a maximum of [\$400] per day and [\$10,000] per policy term unless shown differently in the Mandate section of the contract.]
OUTPATIENT SERVICES:		
Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Day Surgery Expense: includes services related to scheduled surgery performed in a Hospital including the cost of operating room, [laboratory tests,] [x-rays,] [and] [professional fees].	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Anesthesiologist's fees	[30%] of the amount paid to the surgeon (paid at [80%] for Preferred Provider and [60%] for Out of Network) [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]	
Covered Provider's Visit Expenses limited to one visit per day.	[[80%] of Preferred Allowance]	[60%] of Reasonable and Customary Charge
[Physiotherapy Treatments for services prescribed by a Physician for a stated number of treatments. For additional treatment, the referring Physician must issue a new prescription following medical evaluation of the Insured Person's condition. Limited to one visit per day.]	[[80%] of Preferred Allowance] [to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]
Medical Emergency Expenses for use of emergency room and supplies. Treatment must be rendered within [72 hours] of an Accidental Bodily Injury or first onset of a covered Sickness .	[80%] of Preferred Allowance [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury] [Co-Payment: [\$100]]	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury] [Co-Payment: [\$100]]
[Diagnostic X-rays and Laboratory Expenses]	[[80%] of Preferred Allowance] [to a maximum of [\$750] per Sickness or	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$750] per

	Accidental Bodily Injury.]	Sickness or Accidental Bodily Injury.]
[Chemotherapy & Radiation Therapy Expenses]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Injection Expenses when administered in a Physician's office and charged on the Physician's statement.]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Tests and Procedures Expenses – diagnostic services and medical procedures performed by a Physician other than Physician visits, physical therapy, x-rays and laboratory procedures.	[80%] of Preferred Allowance [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Mental and Nervous Disorders: includes all ancillary charges incurred as a result of Mental and Nervous Disorders.]	[[80%] of Preferred Allowance [to a maximum of [\$500] per policy term unless shown differently in the Mandate section of the contract.]]	[60%] of Reasonable and Customary Charge [to a maximum of [\$500] per policy term unless shown differently in the Mandate section of the contract.]]
[Ambulance Service Expense for the use of a commercial or municipal Ambulance if an Insured Person requires the use of such Ambulance .]	[Maximum benefit of [\$125] per Accidental Bodily Injury or Sickness . [Deductible of [\$25] per Accidental Bodily Injury or Sickness .]]	
[Dental Expense for removal of impacted wisdom teeth.]	[[80%] of] the Preferred Allowance subject to a maximum of [\$100] per tooth.]	[60%] of the Covered Provider's Reasonable and Customary Charge subject to a maximum of [\$80] per tooth.
[Dental Expenses as the result of Accidental Bodily Injury to sound, natural teeth.]	[[80%] of] the Preferred Allowance subject to a maximum of [\$100] per tooth.]	[[60%] of] the Covered Provider's Reasonable and Customary Charge subject to a maximum of [\$80] per tooth.]
[Consultant Physician's fees (when requested and approved by attending Physician .)]	[[80%] of Preferred Allowance to a maximum of [\$50] per Sickness or Accidental Bodily Injury .]	[[60%] of Reasonable and Customary Charge to a maximum of [\$50] per Sickness or Accidental Bodily Injury .]
[Allergy Treatment Expenses]	[[80%] of Preferred Allowance] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Braces and Appliances]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$1,000] per Sickness or Accidental Bodily Injury]	
Arkansas Mandated Benefits	See Section II of the Contract	

]

INPATIENT SERVICES:

<p>[Hospital Room & Board while Hospital Confined [subject to the daily semi-private room rate including general nursing care provided by the Hospital.] [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] Semi-private room rate or Intensive Care Unit room rate [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day [up to a maximum of [20] days]</p>
<p>[Miscellaneous Hospital expenses incurred while Hospital Confined including the cost of the [operating room,] [intensive care,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[100% of] Reasonable & Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]] [\$250 per day [up to a maximum of [20] days]</p>
<p>[Hospital expense while Hospital Confined including the cost of the [operating room,] [intensive care,] [room and board,] [laboratory tests,] [x-ray examinations,] [anesthesia,] [drugs (excluding take home drugs) or medicines,] [therapeutic services and supplies]. [Readmissions within [30] days for the same Sickness or Accidental Bodily Injury will be considered a continuation of prior Hospital confinement.] [The date of admission will be counted but not the date of discharge when computing the number of days payable.]]</p>	<p>[[80% of] Semi-private room rate] [[[\$500] per day up to a maximum of [20] days] [[80% of] Reasonable and Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]]</p>
<p>In-Hospital Physician expense. [Does not include expenses for [Surgeon,] [Assistant Surgeon,] [Anesthesiologist] [or] [Second Surgical Opinion.]</p>	<p>[[100% of] Reasonable & Customary Charge] [\$250 per day] [up to a maximum of [20]days]</p>
<p>Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]</p>	<p>[[100% of] Reasonable & Customary Charge [to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]]</p>
<p>[Assistant Surgeon's fees for services of an assistant surgeon required by the Hospital or by the procedure.]</p>	<p>[[30%] of the amount paid to the surgeon] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]]</p>
<p>[Anesthesiologist's fees for services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed.]</p>	<p>[[30%] of the amount paid to the surgeon] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]]</p>
<p>[Registered Nurse Expense for private nursing duty care]</p>	<p>[[[100% of] Reasonable & Customary Charge] [[[\$250] per day [up to a maximum of [20] days]</p>
<p>[[Second Surgical Opinion] [or] [Physician Consultation Expense] when a necessary surgical procedure is recommended; conducted by a board certified specialist</p>	<p>[[5%] of the amount paid to the surgeon]</p>

in the medical field relating to the surgical procedure recommended. This includes x-rays and diagnostic tests.]	
[Preadmission testing]	[[60% of] Reasonable & Customary Charge]
[Mental and Nervous Disorders]	[[60% of] Reasonable and Customary Charge to a maximum of [\$400] per day and [\$10,000] per policy term unless shown differently in the Mandate section of the contract.]
OUTPATIENT SERVICES:	
Surgeon's Fee [limited to one surgical procedure when multiple procedures are performed from the same incision or in immediate succession.] [If multiple procedures are performed through same incision or in immediate succession, benefit will be paid at [50%] for the second procedure and [25%] for all subsequent procedures.]	[100 % of] Reasonable & Customary Charge [subject to a maximum of [\$2,000] per Sickness or Accidental Bodily Injury]
Day Surgery Expense: includes services related to scheduled surgery performed in a Hospital including the cost of operating room, [laboratory tests,] [x-rays,] [and] [professional fees].	[100 % of] Reasonable & Customary Charge [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]
[Anesthesiologist's fees for services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed.]	[[30%] of the amount paid to the surgeon] [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury]
Covered Provider's Visit Expenses limited to one visit per day.	[100 % of] Reasonable & Customary Charge
[Physiotherapy Treatments for services prescribed by a Physician for a stated number of treatments. For additional treatment, the referring Physician must issue a new prescription following medical evaluation of the Insured Person's condition. Limited to one visit per day.]	[100 % of] [Reasonable & Customary Charge] [to a maximum of [\$500] per Sickness or Accidental Bodily Injury .]
Medical Emergency Expenses for use of emergency room and supplies. Treatment must be rendered within [72 hours] of an Accidental Bodily Injury or first onset of a covered Sickness .	[100 %] Reasonable & Customary Charge [subject to a maximum of [\$500] per Sickness or Accidental Bodily Injury] [Co-Payment: [\$100]]
[Diagnostic X-rays and Laboratory Expenses]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$750] per Sickness or Accidental Bodily Injury]
[Chemotherapy & Radiation Therapy Expenses]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Injection Expenses when administered in a Physician's office and charged on the Physician's statement.]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
Tests and Procedures Expenses – diagnostic services and medical procedures performed by a Physician other than Physician visits, physical therapy, x-rays and laboratory procedures.	[60%] of Reasonable and Customary Charge [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Mental and Nervous Disorders: includes all ancillary charges incurred as a result of Mental and Nervous Disorders.]	[[60%] of Reasonable and Customary Charge to a maximum of [\$500] per policy term unless shown differently in the Mandate section of the contract.]
[Ambulance Service Expense for the use of a commercial or municipal Ambulance if an Insured	[Maximum benefit of [\$125] per Accidental Bodily Injury or Sickness . [Deductible of [\$25] per Accidental

Person requires the use of such Ambulance.]	Bodily Injury or Sickness.]
[Dental Expense for removal of impacted wisdom teeth.]	[[80% of] Reasonable and Customary Charge subject to a maximum of [\$350] per tooth.]
[Dental Expenses as the result of Accidental Bodily Injury to sound, natural teeth.]	[[80% of] Reasonable and Customary Charge subject to a maximum of [\$350] per tooth.]
[Consultant Physician's fees (when requested and approved by attending Physician. .)]	[[60%] of Reasonable and Customary Charge to a maximum of [\$50] per Sickness or Accidental Bodily Injury]
[Allergy Treatment Expenses]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$2500] per Sickness or Accidental Bodily Injury]
[Braces and Appliances]	[[60%] of Reasonable and Customary Charge] [to a maximum of [\$1,000] per Sickness or Accidental Bodily Injury]
Arkansas Mandated Benefits	See Section II of the Contract

]

Section III – Accidental Death & Dismemberment Benefits

Accidental:	Benefit Amount:
Loss of Life	[\$3,000]
Loss of Speech and Loss of Hearing	[\$3,000]
Loss of Speech and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	[\$3,000]
Loss of Hearing and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	[\$3,000]
Loss of Hands (Both), Loss of Feet (Both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	[\$3,000]
Loss of Hand, Loss of Foot or Loss of Sight of One Eye (Any One of each)	[\$1,500]
Loss of Speech or Loss of Hearing	[\$1,500]
Loss of Thumb and Index Finger of the same hand	[\$750]

[Section IV] [- Medical Evacuation and Repatriation Benefit

[Class] [1]

Medical Evacuation Benefit Amount: [\$10,000]

Repatriation Benefit Amount: [\$10,000]]

[Section V] – Prescription Drug Benefit

[Class 1] Maximum Benefit Amount: [\$700]

[**Co-Payment:** [\$10] per **Insured Person** per generic prescription when using the [Express Scripts card].
[\$20] per **Insured Person** per brand name prescription when using the [Express Scripts card].
[80%] of **Reasonable and Customary Charge** when not using the [Express Scripts card].]]

Contract

SECTION I – INSURANCE

Subject to all the terms and conditions of this Policy and the payment of required premium, We will provide the following insurance.

MEDICAL EXPENSE BENEFITS

We will pay up to the Maximum Benefit Amount per **Sickness** or **Accidental Bodily Injury**, shown in Section II of the Schedule of Benefits, for **Medical Expenses** incurred by an **Insured Person** due to a covered **Accidental Bodily Injury** or **Sickness**. [The Benefit Amount is payable only for **Medical Expenses** incurred within [the policy period] [12 months] after the date of the initial **Sickness** or **Accidental Bodily Injury**]. The Benefit Amount is subject to the [Deductible,] [Co-Payment] [and] [**Insured Percent**] shown in Section II of the Schedule of Benefits.

[If an **Insured Person** receives care from a **Preferred Provider**, **Medical Expenses** will be paid at the **Preferred Provider** level. If a **Preferred Provider** is not available in the **Insured Person's** network area, **Medical Expenses** will be paid at the level of benefits shown as **Preferred Provider**. If the **Medical Expenses** are incurred as the result of an **Emergency**, such **Medical Expenses** will be paid at the **Preferred Provider** level. In all other situations, reduced or lower benefits will be provided when an **Out of Network** provider is used. The benefits payable are as defined in and subject to all provisions of this Policy.]

Benefits will be paid up to the Maximum Benefit for each service as listed in Section II of the Schedule of Benefits.

[Preferred Provider Information]

By enrolling in this Policy, an **Insured Person** has the [PHCS Preferred Provider Network]. The availability of specific providers is subject to change without notice. A complete listing of **Preferred Providers** is available at [www.phcs.com]. The policy does not require an **Insured Person** to use a **Preferred Provider**.]

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

We will pay the applicable Benefit Amount, shown in Section III of the Schedule of Benefits, if an **Accident** results in a covered loss not otherwise excluded. The **Accident** must occur while an **Insured Person** is insured under this policy, while it is in force. The covered **Loss** must occur within [ninety (90) days] after the **Accident**.

[MEDICAL EVACUATION OR REPATRIATION BENEFIT

If an **Insured Person's** **Sickness** or **Accidental Bodily Injury** causes such **Insured Person** to be **Hospital Confined** for [five (5)] or more days, and as a result the **Insured Person** must be **Medically Evacuated**, then We will pay the **Covered Expenses** for such **Medical Evacuation** up to the Benefit Amount for **Medical Evacuation** shown in Section IV of the Schedule of Benefits.

If an **Insured Person's** **Sickness** or **Accidental Bodily Injury** requires the **Repatriation** of the **Insured Person**, then We will pay the **Covered Expenses** for such **Repatriation** up to the Benefit Amount for **Repatriation** shown in Section IV of the Schedule of Benefits.

The **Medical Evacuation** or **Repatriation** must be recommended by the attending **Physician** and approved and arranged by **Our Assistance Services Administrator**. The Benefit Amount for **Medical Evacuation** or **Repatriation** is payable in addition to any other applicable Benefit Amounts under this policy.]

[PRESCRIPTION DRUG BENEFIT

We will pay for Covered **Prescription Drugs** as a result of **Sickness** or **Accidental Bodily Injury** up to the maximum Benefit Amount shown in Section [V] of the Schedule of Benefits. The Benefit Amount is subject to the **Co-Payment** shown in Section [V] of the Schedule of Benefits.]

SECTION II – ARKANSAS STATE MANDATED INSURANCE BENEFITS

Subject to all the terms and conditions of this Policy and the payment of required premium, We will provide the following Mandated Benefits and any other applicable mandate in accordance with Arkansas insurance laws.

[ALCOHOL AND DRUG DEPENDENCY BENEFIT

We will pay expenses incurred for the **Necessary Care and Treatment** of alcohol and other drug dependency that are not less favorable than for physical illness generally. For each 24 month period We will pay a minimum of \$6,000 for the **Necessary Care and Treatment** of alcohol or drug dependency. No more than half of the maximum benefit amount for alcohol or drug dependency for a twenty-four (24) month period shall be paid for the **Necessary Care and Treatment** of alcohol or drug dependency in any thirty (30) consecutive day period.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

[BREAST RECONSTRUCTION AND MASTECTOMY BENEFIT

We will pay expenses incurred for:

- 1) medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than forty-eight (48) hours unless the decision to discharge the patient before the expiration of the minimum length of stay is made by the attending **Physician** in consultation with the **Insured Person**;
- 2) reconstructive surgery on each breast for which a mastectomy has been performed;
- 3) reconstructive surgery on a non-diseased breast to provide a symmetrical appearance;
- 4) prostheses; and
- 5) physical complications during all stages of a mastectomy, including lymphedemas.]

CANCER DRUG BENEFIT

We will pay expenses incurred for drugs to treat cancer provided that:

- 1) such drugs have been approved for sale by the federal Food and Drug Administration; and
- 2) the drug is recognized as safe and effective for treatment of the specific type of cancer for which it has been prescribed in:
 - a) any of the following standard reference compendia:
 - i) The American Hospital Formulary Service Drug Information;
 - ii) The National Comprehensive Cancer Network Drugs and Biologics Compendium; or
 - iii) The Elsevier Gold Standard's Clinical Pharmacology; or
 - b) two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature; or
 - c) other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner.

We will also pay expenses incurred for the administration of the drug. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

CHILDREN'S PREVENTIVE HEALTH CARE SERVICES BENEFIT

We will pay expenses incurred for **Children's Preventive Care Services** for an **Insured Person's** child who is insured under this **Policy**, for twenty (20) visits at the following intervals:

- 1) six (6) times during the child's first year after birth;
- 2) three (3) times during the next year; and
- 3) annually until age eighteen (18).

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

COLORECTAL CANCER EXAMINATION BENEFIT

We will pay expenses incurred for colorectal cancer examinations and laboratory tests for:

- 1) **Insured Persons** who are fifty (50) years of age or older;
- 2) **Insured Persons** who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
- 3) **Insured Persons** experiencing the following symptoms of colorectal cancer as determined by a **Physician** and:
 - a) bleeding from the rectum or blood in the stool; or
 - b) a change in bowel habits that lasts more than five (5) days.

The colorectal screening shall involve an examination of the entire colon, including the following examinations or laboratory tests, or both:

- 1) an annual fecal occult blood test or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) a double –contrast barium enema every five (5) years; or
- 3) a colonoscopy every ten (10) years; and
- 4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up surgery:

- 1) if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
- 2) for **Insured Persons** with one (1) or more neoplastic polyps or adenomatous polyps, follow-up is recommended in three (3) years;
- 3) if single tubular adenoma of less than one centimeter (1cm) is found, follow-up is recommended in five (5) years; and
- 4) for **Insured Persons** with large sessile adenomas greater than three centimeters (3cm), follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

[CONTRACEPTIVES BENEFIT

We will pay expenses incurred for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.]

DENTAL CARE BENEFIT

We will pay expenses incurred for anesthesia and hospital or ambulatory surgical facility charges for services provided in conjunction with dental care that is provided to an **Insured Person** if:

- 1) the **Insured Person's Physician** certifies that because of the **Insured Person's** age or condition, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and
- 2) the **Insured Person** is a child age seven (7) or under who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act, §17-82-101, et seq., to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
- 3) the **Insured Person** has been diagnosed with a serious mental or physical condition; or
- 4) the **Insured Person** has a significant behavioral problem as determined by the **Insured Person's Physician**.

DIABETES COVERAGE BENEFIT

We will pay expenses incurred for laboratory and diagnostic tests for all types of diabetes. In addition We will pay for expenses incurred for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. Such coverage includes **Diabetes Equipment**, in accordance with the **Insured Person's** treatment plan, drugs and supplies prescribed by a prescribing **Physician**. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

DIABETES SELF-MANAGEMENT TRAINING BENEFIT

We will pay expenses incurred for self-management training provided by an appropriately licensed health care professional who has completed an educational program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Coverage is limited to one (1) training program per lifetime per **Insured Person**. Additional diabetes self-management training may be

provided in the event the **Insured Person's Physician** prescribes additional diabetes self-management training and is needed because of a significant change in the **Insured Person's** symptoms or conditions. Diabetes self-management training shall be provided only upon prescription by the **Insured Person's Physician**.

HEARING AID BENEFIT

We will pay expenses incurred for a hearing aid or hearing instrument sold by a professional licensed by the state to dispense a hearing aid or hearing instrument. The benefit is limited to [\$1,400] per ear every three years.

[HOSPICE CARE BENEFIT

We will pay expenses incurred for **Hospice** services to a terminally ill **Insured Person** who has a life expectancy of six (6) months or less. **Hospice** services include, but are not limited to:

- 1) **Physician's** services;
- 2) care provided by or under the supervision of a nurse;
- 3) social services, volunteer services and counseling services provided by professional or volunteer staff under professional supervision.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.]

IN VITRO FERTILIZATION BENEFIT

We will pay the expenses incurred for in vitro fertilization services performed at:

- 1) a medical facility licensed or certified by the Department of Health;
- 2) a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics; or
- 3) a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilizations.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

[MAMMOGRAPHY BENEFIT

We will pay expenses incurred for mammographic examinations as follows:

- 1) a baseline mammogram for women who are thirty-five (35) to forty (40) years of age;
- 2) a mammogram for women who are forty (40) to forty-nine (49) years of age every one (1) to two (2) years based on the recommendation of the woman's **Physician**; and
- 3) a mammogram every year for women who are fifty (50) years of age or older.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.]

MATERNITY AND NEWBORN BENEFIT

We will pay expenses incurred for inpatient care for mother and newborn in a health care facility for:

- 1) forty-eight (48) hours following a normal vaginal delivery; or
- 2) ninety-six (96) hours following a caesarean delivery.

We will also pay expenses incurred for newborn testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law.

Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS BENEFIT

We will pay expenses incurred for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a **Physician** for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the cost of the medical food or low protein modified food products for an **Insured Person** or an **Insured Person's Dependent** exceeds the income tax credit of \$2,400.00 per year per person allowed under §23-79-702. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

MENTAL ILLNESS BENEFIT

We will pay expenses incurred for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of those with developmental disorders. Benefits for the diagnosis and mental health treatment of mental illnesses and developmental disorders will be paid under the same terms and conditions as provided for the treatment of other medical illnesses or conditions.

[MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD BENEFIT

We will pay expenses for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and non-surgical procedures. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.]

PROSTATE CANCER SCREENING BENEFIT

We will pay expenses incurred for one (1) screening per year for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines. Such screening must be performed by a qualified medical professional. If a qualified medical professional recommends that an **Insured Person** undergo a prostate specific antigen blood test, **We Will** pay the expenses incurred for such test even if the **Insured Person** had a digital rectal examination and the examination result was negative. This benefit is not subject to a deductible.

SPEECH, HEARING AND LANGUAGE BENEFIT

We will pay expenses incurred for the diagnosis and treatment of loss or impairment of speech or hearing. Benefits are subject to the same terms and conditions applicable to all other benefits under the Policy.

Limitation on Speech, Hearing and Language Benefit

Coverage does not apply to hearing instruments or devices.

SECTION III - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

Eligibility

A person becomes insured under this Policy if such person is a member of an eligible Class of **Insured Persons** as shown in Section I of the Schedule of Benefits. **We** have the right to investigate student status and attendance records to verify that the eligibility requirements have been met.

Effective Date of Insurance for an Insured Person

Insurance for an **Insured Person** becomes effective on the latest of:

- 1) the effective date of this Policy;
- 2) the date on which such person first meets the eligibility criteria as an **Insured Person**; or
- 3) the beginning of the period for which required premium is paid for such **Insured Person**, except that:
 - a) for a newborn child, coverage will begin from the moment of birth. Payment of the required premium for newborn children must be furnished to **Us** within ninety (90) days after the date of birth in order to continue coverage beyond such ninety (90) day period;
 - b) for an adopted child, coverage will begin upon the date of placement by a licensed placement agency of the child for purposes of adoption in the home of an **Insured Person**. Payment of the required premium for adopted children must be furnished to **Us** within thirty-one (31) days of the petition date or placement date in order to continue coverage beyond such thirty-one (31) day period; and
 - c) for a spouse [or domestic partner], coverage will begin on the date of marriage [or on the date of the civil union] to the **Insured Person**. Payment of the required premium for the spouse [or domestic partner] must be furnished to **Us** within thirty-one (31) days after the date of marriage [or the date of the civil union] in order to continue coverage beyond such thirty-one (31) day period.

Termination of Insurance for an Insured Person

Insurance for an **Insured Person** automatically terminates on the earliest of:

- 1) the termination date of this Policy;
- 2) the expiration of the period for which required premium has been paid for such **Insured Person**;
- 3) the date on which a person no longer meets the eligibility criteria as an **Insured Person**;
- 4) the last date of the period for which premium has been paid following the date a **Dependent** ceases to be a **Dependent** as defined.

Termination is subject to the Extension of Benefits provision.

Partial Year Enrollment/Refund of Premium

Except for medical withdrawal due to a covered **Accidental Bodily Injury** or **Sickness**, any student withdrawing from school during the first thirty-one (31) days of the period for which coverage is purchased will not be insured under the Policy and a full refund of the premium will be made. Students withdrawing after such thirty-one (31) day period will remain covered under the Policy for the full period for which premium has been paid and no refund will be allowed.

Insured Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the **Company** [within ninety (90) days of entry into the armed forces].

Continuation of Benefits

We will continue to pay benefits under the policy for an **Insured Person** who is hospitalized on the date of termination if the policy is terminated and replaced by a group policy issued by another insurer. Any payment required is subject to all terms, limitations and conditions of the policy except those relating to termination of SH 4000-AR

benefits. Any obligation by us will continue until the hospital confinement ends of hospital benefits under the policy are exhausted, whichever is earlier.

Continuation of Coverage

Insured Persons, and their eligible **Dependents**, whose insurance has terminated because they are no longer a member of the group or because there is a change in marital status shall be entitled to continue their coverage provided the following:

1. the **Insured Person** has been continuously insured under the policy during the entire three (3) month period prior to the termination of membership or change in marital status;
2. the **Insured Person** is not or can not be covered by Medicare or any other group accident and health policy.
3. the **Insured Person** must request such continuation in writing within ten (10) days of the date coverage would otherwise terminate and must pay to the **Policyholder**, on a monthly basis, the amount of contribution required to continue coverage.

Continuation of coverage will end upon the earliest of the following dates:

1. one hundred twenty (120) days after the continuation of coverage began;
2. the end of the period for which the **Insured Person** made a timely contribution;
3. the contribution due date following the date the **Insured Person** becomes eligible for Medicare; or
4. the date on which the policy is terminated or the group withdraws from the plan.

SECTION IV –EXCLUSIONS AND LIMITATIONS

The following exclusions apply to all Benefits and Hazards. Additional exclusions, limitations or conditions may also apply to specific Benefits or Hazards. Please read this entire Policy carefully.

Insurance does not apply to any **Loss** or **Medical Expense** which results from:

1. any treatment, service or supply that is not required for the care and treatment of **Accidental Bodily Injury** or **Sickness**, or any service, treatment or supply that is not recommended by the attending **Covered Provider**;
2. **Elective Surgery or Elective Treatment**;
3. any treatment, service or supply that is **Experimental or Investigational**;
4. cosmetic surgery or treatments;
5. a **Pre-existing Condition** that results in any service, treatment or supply within the first six (6) months following the **Insured Person's** effective date of coverage under this Policy unless during the period immediately preceding the **Insured Person's** effective date under this Policy, the **Insured Person** was covered under prior **Creditable Coverage** for at least six (6) months. **Creditable Coverage** of less than six (6) months will be credited toward satisfying this **Pre-Existing Condition** exclusion;
6. any treatment, service or supply that is provided normally without charge by the **Policyholder's** health center, infirmary or **Hospital**, [or by any person employed by or contracted with the **Policyholder** [including team **Physicians** and trainers]];
7. any treatment, service or supply that is provided in a government **Hospital** unless there is a legal obligation to pay such charges in the absence of other insurance;
8. any treatment, service or supply which is received without charge or legal obligation to pay or would not routinely be paid in the absence of insurance;
9. any treatment, service or supply that is provided by an **Insured Person's Immediate Family Member**;
10. **Accidental Bodily Injury** or **Sickness** for which benefits are payable under any Workers Compensation or Occupational Disease Law, Employers Liability Law, Public Assistance Programs or Occupational Benefit Plans;
11. a motor vehicle **Accident** for which benefits are payable from other valid insurance;
12. declared or undeclared **War**;
13. **Accidental Bodily Injury** sustained or **Sickness** contracted while the **Insured Person** is participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to Reserve or National Guard active duty for training unless it extends beyond thirty-one (31) days;
14. [treatment occurring outside of the United States;]
15. routine physical examinations, preventive testing or treatment, screening exams or testing in the absence of **Sickness** or **Accidental Bodily Injury** unless specifically covered elsewhere in the Policy;
16. expenses for preventative medicines, vaccines, [or **Prescription Drugs**] unless specifically covered elsewhere in the Policy;
17. [**Prescription Drugs**, services or supplies as follows:
 - a. therapeutic devices or appliances, including hypodermic needles or syringes prescribed by a **Physician** for the purpose of administering medications for medical conditions, provided such medications are not

- covered under the Policy, support garments and other non-medical substances;
- b. immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - c. drugs labeled **Experimental or Investigational**;
 - d. anabolic steroids used for body building;
 - e. drugs used to treat or cure baldness;
 - f. drugs used for the purpose of weight control;
 - g. growth hormones;
 - h. refills in excess of the number specified or dispensed after one year of the date of prescription;]
18. [**Off-Label Drug Use** unless specifically covered elsewhere in the Policy;]
 19. dental treatment, except for treatment (a) for the removal of impacted wisdom teeth or (b) resulting from **Accidental Bodily Injury** to sound, natural teeth;
 20. prescriptions and examinations for, or repair and replacement of, eyeglasses or contact lenses;
 21. [hearing examinations or hearing aids or other treatment for hearing defects and problems, except for newborn hearing for the first thirty-one (31) days of coverage. Hearing defects means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;]
 22. [orthopedic appliances, orthotics or other devices used for treatment of a foot or conditions relating to a foot including but not limited to weak, strained or flat feet, corns, calluses, bunions, or toenails;]
 23. an **Insured Person's** commission or attempted commission of any illegal act including but not limited to any felony;
 24. [an **Insured Person** being intoxicated. Intoxication is defined by the laws of the jurisdiction where treatment is received;]
 25. [an **Insured Person** being under the influence of any narcotic or other controlled substance unless such narcotic or other controlled substance is taken and used as prescribed by a **Physician**;]
 26. [sex changes, sexual enhancement drugs, sexual dysfunctions or inadequacies with the exception of penile prosthesis required for physiological impotence;]
 27. [suicide, attempted suicide, self-inflicted injury or attempted self-inflicted injury unless covered under benefits for Mental Illness;]
 28. completion of forms by the **Covered Provider** or fees for appointments scheduled and not kept;
 29. [treatment for smoking cessation;]
 30. [addiction and co-dependency treatment, services or supplies unless specifically covered elsewhere in the Policy;]
 31. [weight management, weight reduction, nutrition programs, treatment for obesity, or surgery for removal of excess skin or fat;]
 32. [over-the-counter medication or **Durable Medical Equipment** unless specifically covered elsewhere in the Policy;]
 33. membership fees to a spa or health club, fitness training or exercise equipment;
 34. [rest cures, custodial care or non-medical care;]

35. [maintenance therapy which is defined as those therapy services rendered to an **Insured Person** who is no longer making documentable progress to maintain the level of progress previously attained;]
36. [an **Insured Person's** participation in intercollegiate or professional sports, including practice, conditioning, play and travel;]
37. [an **Insured Person** riding as a passenger in, entering or exiting any aircraft, except as a fare-paying passenger in an aircraft owned or operated by a **Scheduled Airline**;]
38. [a motor vehicle **Accident** if the **Insured Person** is not properly licensed to operate the motor vehicle within the jurisdiction in which the **Accident** takes place [, except in a Driver's Education Program]. [This exclusion will not apply to passengers if they are **Insured Persons** under this Policy;]
39. [**Accidental Bodily Injury** resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle [and/or off-road four-wheeled motorized vehicles]), [personal water craft or bungee jumping;]]
40. the **Insured Person** engaging in or participating in a motorized vehicular race or speed contest including training or practice;
41. the **Insured Person** engaging in or participating in scuba diving to depths of more than 100 feet; skydiving; hang-gliding or para-gliding; parascending other than over water; bungee jumping; mountaineering or rock climbing normally requiring the use of guides or ropes; or caving;
42. [injury resulting from fighting, except in self-defense.]

With respect to **Accidental** Death & Dismemberment Benefit only, the following exclusion also applies:

Insurance does not apply to any **Accident, Accidental Bodily Injury** or **Loss** caused by or resulting from the **Insured Person's** emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to an **Insured Person's** bacterial infection caused by an **Accident** or **Accidental** consumption of a substance contaminated by bacteria.

SECTION V - DEFINITIONS

For the purpose of these definitions, the singular includes the plural and the plural includes the singular, unless otherwise noted. Male pronouns whenever used include female pronouns.

Accident or Accidental

Accident or **Accidental** means a sudden, unforeseen, and unexpected event which:

- 1) happens by chance;
- 2) is independent of illness, disease or other bodily malfunction or medical or surgical treatment thereof;
- 3) occurs while the **Insured Person** is insured under this policy which is in force; and
- 4) is the direct cause of loss.

Accidental Bodily Injury

Accidental Bodily Injury means bodily injury, which:

- 1) is **Accidental**;
- 2) is the direct cause of a loss; and
- 3) occurs while an **Insured Person** is insured under this Policy, which is in force.

Ambulance

Ambulance means a vehicle which is licensed solely as an **Ambulance** by the local regulatory body to provide transportation to a **Hospital** or transportation from one **Hospital** to another for those individuals who are unable to travel to receive medical care by any other means or the **Hospital** cannot provide the needed care. **Emergency** transportation includes **Ambulance** services provided through the "911" **Emergency** response system.

[Assistance Services Administrator

Assistance Services Administrator means the organization that contracts with the **Company** to provide **Medical Evacuation** and **Repatriation** services to an **Insured Person**.]

Children's Preventive Health Care Services

Children's Preventive Health care Services means **Physician**-delivered or **Physician**-supervised services for an **Insured Person's** child from birth through eighteen (18) years of age, with **Periodic Preventive Care Visits**, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests.

Company

Company means Federal Insurance Company.

Complications of Pregnancy

Complications of Pregnancy means:

- 1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and
- 2) nonelective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include:

- 1) false labor;
- 2) occasional spotting;
- 3) **Physician** prescribed rest during the period of pregnancy;
- 4) morning sickness;
- 5) hyperemesis gravidarum;
- 6) pre-eclampsia; or
- 7) similar conditions associated with the management of a difficult pregnancy but which are not distinctly related to the pregnancy.

[Conveyance

Conveyance means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.]

[Co-Payment

Co-Payment means the charge payable by the **Insured Person** for certain **Medical Expenses**.

[Covered Expenses

With respect to **Medical Evacuation**, **Covered Expenses** means the cost for:

- 1) a land, water or air **Conveyance**, required to transport an **Insured Person** during a **Medical Evacuation**. Special transportation by, but not limited to, air ambulances, land ambulances and private motor vehicles must:
 - a) be recommended by an attending **Physician**; and
 - b) comply with the standard regulations of the **Conveyance** transporting an **Insured Person**.

The means of transportation that is best suited to accommodate an **Insured Person**, based on the seriousness of an **Insured Person's** condition, will be used.

- 2) medical supplies and services which are:
 - a) ordered or prescribed by an attending **Physician**; and
 - b) are, in the opinion of an attending **Physician**, necessarily incurred in connection with the **Medical Evacuation** of an **Insured Person**.

With respect to **Repatriation**, **Covered Expenses** means the cost for:

- 1) **Repatriation** of an **Insured Person**; and
- 2) medical supplies and services which:
 - a) are ordered or prescribed by an attending **Physician**; and
 - b) are, in the opinion of an attending **Physician**, necessarily incurred in connection with **Repatriation** of an **Insured Person**; or
 - c) are necessary for embalming, cremation, transportation and purchase of a shipping container as required by applicable law or regulation.

With respect to **Medical Evacuation** and **Repatriation**, all transportation arrangements made for an **Insured Person** will be by the most direct and economical route. All **Covered Expenses** must be arranged by and receive the prior approval of **Our Assistance Service Administrator**.

Covered Expenses do not include those expenses incurred by an **Insured Person** for **Sickness** or **Accidental Bodily Injury** which occurs while an **Insured Person** is:

- 1) traveling against the advice of a **Physician**; or
- 2) traveling for the purpose of obtaining medical treatment.]

[Covered Provider

Covered Provider means a:

- 1) **Physician**;
- 2) **Licensed Mental Health Professional**;
- 3) psychotherapist;
- 4) chiropractor acting within the scope of his or her license;
- 5) physical therapist;
- 6) dentist while providing oral surgical care, services, procedures or benefits covered by this policy;
- 7) podiatrist;
- 8) optometrist while providing visual services which are covered by this policy;
- 9) certified nurse midwife while acting within the lawful scope of practice for a certified nurse midwife;
- 10) certified registered nurse anesthetist or nurse practitioner designated as such by the board of registration in nursing while providing services that are within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice;
- 11) **Physician** assistant performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioner.

Covered Provider does not include an **Insured Person** or an **Immediate Family Member** of an **Insured Person**.

Creditable Coverage

Creditable Coverage means insurance under any of the following health plans with no lapse in coverage of more than sixty-three (63) days during the period immediately preceding the **Insured Person's** effective date under this Policy:

- 1) a group health plan;
- 2) a health plan, including but not limited, to a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program;
- 3) Part A or Part B of Title XVIII of the Social Security Act, as amended;
- 4) Title XIX of the Social Security Act, as amended, other than coverage consisting solely of benefits under section 1928;
- 5) 10 U.S.C. chapter 55, as amended;
- 6) a medical care program of the Indian Health Service or of a tribal organization;
- 7) a state health benefits risk pool;
- 8) a health plan offered under 5 U.S.C. chapter 89, as amended;
- 9) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701 (c)(I)(I), as amended by Public Law 104-191; or
- 10) a health benefit plan under the Peace Corps Acts, 22 U.S.C. 2504(e), as amended; or
- 11) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

Creditable Coverage includes continuation coverage but does not include **Accident-only**, credit, coverage for on-site medical clinics, disability income, **Medicare** supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Dependent

Dependent means the **Insured Person's Dependent Child**, [or] **Spouse** [, or **Domestic Partner**]

Dependent Child

Dependent Child means an **Insured Person's** unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of placement with an **Insured Person**. The **Dependent Child** must be primarily dependent upon such **Insured Person** for maintenance and support, and must be:

- 1) under the age of [nineteen (19)];
- 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an **Institution of Higher Learning** ; or
- 3) classified as an **Incapacitated Dependent Child**.

Diabetes Equipment

Diabetes Equipment means:

- 1) blood glucose monitors;
- 2) blood glucose monitoring strips for home use;
- 3) voice-synthesizers for blood glucose monitors for use by the legally blind;
- 4) visual magnifying aids for use by the legally blind;
- 5) urine glucose strips;
- 6) ketone strips;
- 7) lancets;
- 8) insulin and insulin syringes;
- 9) insulin pumps and insulin pump supplies and insulin pens;
- 10) therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating **Physician** and prescribed by a podiatrist or other qualified **Physician** and furnished by a podiatrist, orthotist, prosthetist or pedorthist.

Domestic Partner

Domestic Partner means a person designated by an **Insured Person** who is registered as a **Domestic Partner** or legal equivalent under laws of the governing jurisdiction or who:

- 1) is at least [eighteen 18] years of age and competent to enter into a contract;
- 2) is not related to the **Insured Person** by blood;
- 3) has exclusively lived with the **Insured Person** for at least [one (1) year] prior to the date of enrollment;
- 4) is not legally married or separated; and
- 5) as of the date of enrollment, has with the **Insured Person** at least two (2) of the following financial arrangements:
 - a) a joint mortgage or lease;
 - b) a joint bank account;
 - c) joint title to or ownership of a motor vehicle or status as a joint lessee on a motor vehicle lease; or
 - d) a joint credit card account with a financial institution.

Neither the **Insured Person** nor the **Domestic Partner** can be married to, nor in a civil union with, anyone else.

[Durable Medical Equipment]

Durable Medical Equipment means equipment that can be expected to make a meaningful contribution to the **Insured Person's Accidental Bodily Injury** or **Sickness** and is:

- 1) primarily and customarily used for medical purposes;
- 2) equipped with features and functions that are generally not required in the absence of an **Accidental Bodily Injury** or **Sickness**;
- 3) routinely used in a **Hospital** but also used effectively in a non-medical facility; and
- 4) prescribed by a **Covered Provider** for the **Insured Person's** rehabilitation.]

[Elective Surgery or Elective Treatment]

Elective Surgery or Elective Treatment means any surgery or treatment that:

- 1) is not necessitated by a pathological or traumatic change in the function or structure of any part of the body;
- 2) is for the **Insured Person's** convenience; and
- 3) does not require immediate attention.

[Emergency]

Emergency means the unexpected onset of an **Accidental Bodily Injury** or **Sickness** which requires immediate or urgent medical attention which, if not provided, could result in a loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. **Emergency** does not include **Elective Surgery or Elective Treatment** or routine care.

[Emergency Medical Treatment]

Emergency Medical Treatment means **Hospital** treatment for a medical condition which:

- 1) arises suddenly and unexpectedly; and
- 2) if left untreated could result in loss of life, or in serious deterioration of an **Insured Person's** medical condition.]

Experimental or Investigational

Experimental or Investigational means any drug, device or medical treatment (collectively “Technology”) that satisfies any of the following criteria:

- 1) the Technology cannot be lawfully marketed within the United States without the approval of the U.S. Food and Drug Administration (“FDA”) and the FDA has given no approval to market the Technology at the time the Technology is furnished;
- 2) the Technology for the particular diagnosis or set of indications is:
 - (a) the subject of ongoing Phase I or II clinical trials; or
 - (b) the investigational arm of a Phase III study or under study to determine its:
 - (i) maximum tolerated dosage;
 - (ii) efficacy;
 - (iii) safety; or
 - (iv) toxicity compared with the standard means of treatment or diagnosis.
- 3) as demonstrated by **Medical Evidence**, expert opinion regarding the Technology has formed a consensus that further studies or clinical trials are necessary to determine the Technology’s:
 - (a) maximum tolerated dosage;
 - (b) efficacy;
 - (c) safety, or
 - (d) toxicity compared with the standard means of treatment or diagnosis;
- 4) the Technology was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

Any treatment that results from an **Experimental or Investigational** Technology will also be considered **Experimental or Investigational**.

[Hospice

Hospice means a centrally coordinated program ensuring continuity and consistency of home and inpatient care provided directly through an inpatient facility operating under its hospice license or through an agreement.]

Hospital

Hospital means a public or private institution which:

- 1) is licensed in accordance with the laws of the jurisdiction where it is located;
- 2) is accredited by the Joint Commission on Accreditation of Hospitals;
- 3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- 4) provides organized facilities for diagnosis and medical or surgical treatment;
- 5) provides twenty-four (24 hour) nursing care;
- 6) has a **Physician** or staff of **Physicians** ; and
- 7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.

Hospital Confined or Hospital Confinement

Hospital Confined or **Hospital Confinement** means a stay of eighteen (18) or more consecutive hours as a resident bed-patient in a **Hospital**.

Immediate Family Member

Immediate Family Member means an **Insured Person’s**:

- 1) **Spouse** or **Domestic Partner**;
- 2) children including adopted children or stepchildren;
- 3) legal guardians or wards;
- 4) siblings or siblings-in-law;
- 5) parents or parents-in-law;
- 6) grandparents or grandchildren;
- 7) aunts or uncles;
- 8) nieces and nephews.

Immediate Family Member also means a **Spouse's** or **Domestic Partner's** children, including adopted children or stepchildren; legal guardians or wards; siblings or siblings-in-law; parents or parents-in-law; grandparents or grandchildren; aunts or uncles; nieces or nephews.

Incapacitated Dependent Child

Incapacitated Dependent Child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on an **Insured Person** for support and maintenance. The incapacity must have occurred while the child was:

- 1) under the age of [nineteen (19)]; or
- 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an **Institution of Higher Learning**.

Institution of Higher Learning

Institution of Higher Learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12th) grade.

Insured Percent

Insured Percent means the percentage of **Medical Expenses** that **We** pay for each **Accidental Bodily Injury** or **Sickness**.

Insured Person

Insured Person means a person:

- 1) who is eligible for coverage as the insured or as a **Dependent**;
- 2) who has been accepted for coverage or has been automatically added;
- 3) who has paid the required premium; and
- 4) whose coverage has become effective and has not terminated.

Intensive Care

Intensive Care means treatment in an **Intensive Care Unit**.

Intensive Care Unit

Intensive Care Unit means a specifically designed facility of the **Hospital** that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit.

Intensive Care Unit does not mean any of the following step-down units:

- 1) progressive care;
- 2) sub-acute intensive care;
- 3) intermediate care units;
- 4) private monitored rooms;
- 5) observation units; or
- 6) other facilities which do not meet the standards for intensive care.

Licensed Mental Health Professional

Licensed Mental Health Professional means a:

- 1) **Physician** who specializes in the practice of psychiatry;
- 2) licensed psychologist;
- 3) licensed independent clinical social worker;
- 4) licensed mental health counselor; or
- 5) licensed nurse mental health clinical specialist.

Loss

Loss means **Accidental: Loss of Foot, Loss of Hand, Loss of Hearing, loss of life, Loss of Sight, Loss of Sight of One Eye, Loss of Speech, and Loss of Thumb and Index Finger** which occurs within [ninety (90) days] after the **Accident**.

Loss of Foot

Loss of Foot means the complete severance of a foot through or above the ankle joint. **We** will consider such severance a **Loss of Foot** even if the foot is later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.

Loss of Hand

Loss of Hand means complete severance, as determined by a **Physician**, of at least four (4) fingers at or above the metacarpal phalangeal joint on the same hand or at least three (3) fingers and the thumb on the same hand. **We** will consider such severance a **Loss of Hand** even if the hand, fingers or thumb are later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.

Loss of Hearing

Loss of Hearing means permanent, irrecoverable and total deafness, as determined by a **Physician**, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a **Physician**.

Loss of Sight

Loss of Sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a **Physician**.

Loss of Sight of One Eye

Loss of Sight of One Eye means permanent loss of vision of one eye. Remaining vision in that eye must be no better than 20/200 using a corrective aid or device, as determined by a **Physician**.

Loss of Speech

Loss of Speech means the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices, as determined by a **Physician**.

Loss of Thumb and Index Finger

Loss of Thumb and Index Finger means complete severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand, as determined by a **Physician**. **We** will consider such severance a **Loss of Thumb and Index Finger** even if a thumb, an index finger or both are later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.

Medicaid

Medicaid means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as then constituted or later amended.

[Medical Evacuation or Medically Evacuated

Medical Evacuation or Medically Evacuated means the emergency transportation of an **Insured Person** from the location where such **Insured Person** is injured or becomes ill to the nearest **Hospital** where appropriate medical care and treatment can be provided.]

Medical Evidence

Medical Evidence means:

- 1) a published report, a clinical study, or a review article in a peer-reviewed professional medical or scientific journal;
- 2) written protocols used by a facility studying a drug, device or medical treatment that is substantially identical to the drug, device or medical treatment furnished; or
- 3) written informed consent used by a facility studying a drug, device or medical treatment that is substantially identical to the drug, device or medical treatment furnished.

Medical Expenses

Medical Expenses means the **Reasonable and Customary Charges** for any medical treatment, service or supply given by a **Covered Provider** that is:

- 1) not in excess of the maximum amount payable for services as specified in the Schedule of Benefits;
- 2) not in excess of the charges that would have been made in the absence of this insurance;
- 3) incurred while this Plan is in force as to the **Insured Person**; and
- 4) in excess of any deductible amount.

Medicare

Medicare means the government program established to provide health care benefits including Part A and Part B as established by Title XVIII of the Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Necessary Care and Treatment

Necessary Care and Treatment means treatment, including detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, in an alcohol or drug dependency treatment facility or care and treatment in a hospital.]

Occupational Therapy

Occupational Therapy means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a **Physician** who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan must be reviewed and certified at least every two (2) months by such **Physician**.

[Off-Label Drug Use

Off-Label Drug Use means the use of a drug for the purpose other than that for which it was approved by the U.S. Food and Drug Administration (FDA). **Off-Label Drug Use** does not mean a drug:

- 1) that has been approved by the FDA at the time the drug is furnished; and
- 2) which is necessary for the prescribed indication; and
- 3) which is supported by adequate medical and scientific evidence as being safe and effective for the prescribed indication, as noted in the Centers for Medicare & Medicaid Services approved compendia, or in a well-recognized major peer reviewed medical journal, or in the published results of a clinical trial presenting data that supports the use as safe and effective.]

[Out-of-Network

Out-of-Network means providers who have not agreed to any prearranged fee schedules.]

Periodic Preventive Care Visits

Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Physician

Physician means a licensed practitioner of the healing arts, acting within the scope of his or her license to the extent provided by the laws of the jurisdiction in which medical treatment is provided. **Physician** does not include an **Insured Person**, or an **Immediate Family Member** of an **Insured Person**.

Physiotherapy

Physiotherapy means treatment provided by a licensed Physical Therapist.

Policyholder

Policyholder means the entity identified in the Insuring Agreement.

Pre-Existing Condition

Pre-Existing Condition means a **Sickness** or **Accidental Bodily Injury** which, during the six (6) month period prior to the **Insured Person's** effective date of coverage under this Policy, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical

advice, diagnosis, care or treatment was recommended or received. **Pre-Existing Condition** does not include pregnancy.

Preferred Allowance

Preferred Allowance means the amount a **Preferred Provider** will accept as payment in full for **Medical Expenses**.]

Preferred Provider

Preferred Provider means the **Covered Providers** and **Hospitals** who have contracted to provide specific medical care at negotiated prices. **Preferred Providers** in the local school area are: [NEHCA HMO-PP0 Hospitals and Physicians].]

Prescription Drug

Prescription Drug means medication that, under U.S. Federal law, may only be dispensed with a written prescription and is approved for general use by the Food and Drug Administration.

Proof of Loss

Proof of Loss means written evidence acceptable to **Us** that a **Loss** has occurred.

Reasonable and Customary Charge

Reasonable and Customary Charge means the lesser of:

- 1) the usual charge made by **Covered Providers** and **Hospitals** for a given service or supply; or
- 2) the charge **We** reasonably determine to be the prevailing charge made by **Physicians** or other health care providers for a given service or supply in the geographical area where it is furnished.

Repatriation

Repatriation means the necessary arrangements for the return of an **Insured Person's** remains to an **Insured Person's** country or state of origin in the event of such **Insured Person's** loss of life.]

Scheduled Airline

Scheduled Airline means an airline which is either:

- 1) registered and certified by the Government of the United State of America to carry passengers on a regularly scheduled basis; or
- 2) registered and certified by any other governmental authority with competent jurisdiction to carry passengers on a regularly scheduled basis.

Sickness

Sickness means an illness or disease which occurs while the Policy is in-force and which results in **Medical Expenses**. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same **Sickness**. **Sickness** includes **Complications of Pregnancy**.

Spouse

Spouse means an **Insured Person's** husband or wife who is recognized as such by the laws of the jurisdiction in which the **Insured Person** resides.

War

War means:

- 1) hostilities following a formal declaration of war by a governmental authority;
- 2) in the absence of a formal declaration of war by a governmental authority, armed, open, and continuous hostilities between two (2) countries; or
- 3) armed, open, and continuous hostilities between two (2) factions, each in control of territory, or claiming jurisdiction over the geographic area of hostility.

We, Ours and Us

We, Ours and Us means Federal Insurance Company.

SECTION VI – GENERAL PROVISIONS

Beneficiary

The **Benefit Amount** for covered **Accidental** loss of life will be paid to the first surviving party in the following order:

- 1) the Insured **Person's Spouse** [or **Domestic Partner**];
- 2) in equal shares to the **Insured Person's** surviving children;
- 3) in equal shares to the **Insured Person's** surviving parents;
- 4) in equal shares to the **Insured Person's** surviving brothers and sisters;
- 5) the **Insured Person's** estate.

All other **Benefit Amounts** are paid to the **Insured Person**, unless otherwise directed by an **Insured Person** or an **Insured Person's** designee, or unless otherwise noted in this policy.

If any beneficiary has not reached the legal age of majority, then **We** will pay such beneficiary's legal guardian.

Benefit Assignment

An **Insured Person** may assign Benefit Amounts other than those for loss of life. Such assignment must be in writing, signed by the **Insured Person** and filed with the **Policyholder**. The assignment must be provided to **Us** at the time of claim or at such other time as **We** may require. **We** do not assume the responsibility for the validity of any assignment.

Certificate

When required by law, **We** will issue to the **Policyholder** for delivery to the **Insured Person** a Certificate of Insurance. The Certificate of Insurance will describe the benefits, exclusions, limitations, and conditions of this Policy and state to whom benefits are payable. Any subsequent changes to this Policy will also apply to the existing Certificates of Insurance.

Changes

This Policy can only be changed by a written endorsement that becomes a part of this Policy. The endorsement must be approved by one of **Our** officers and signed by one of **Our** authorized representatives. No agent has the authority to change this Policy or waive any of its provisions.

Compliance by Policyholder and Insured Person

We have no duty to provide insurance under this Policy unless the **Policyholder**, the **Insured Person** and the beneficiary, if applicable, have fully complied with all the terms and conditions of this Policy.

Claim Notice

Written Claim Notice must be given to **Us** or any of **Our** brokers or appointed agents within [twenty (20)] days after the date of the **Loss** or **Medical Expense** or as soon as reasonably possible. Notice must include enough information to identify the **Insured Person** and **Policyholder**. Failure to give Claim Notice within [twenty (20)] days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible.

Claim Forms

When **We** receive notice of an **Accidental** Death or Dismemberment claim, **We** will send the **Insured Person** or the **Insured Person's** designee, within [fifteen (15)] days, forms for giving **Proof of Loss** to **Us**. If the **Insured Person** or the **Insured Person's** designee does not receive the forms, then the **Insured Person** or an **Insured Person's** designee should send **Us** a written description of the **Loss**. This written description should include information detailing the occurrence, type and extent of the **Loss** for which the claim is made.

Claim Proof of Loss

Complete **Proof of Loss** must be given to **Us** within [ninety (90)] days after the date of **Loss**, or as soon as reasonably possible. Failure to give complete **Proof of Loss** within these time frames will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible, and in no event later than one (1) year after the deadline to submit complete **Proof of Loss**, except in cases where the claimant lacks legal capacity.

Claim Payment

Within [thirty (30)] days following receipt of the Claim Notice or complete **Proof of Loss**, **We** will either (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing.

Claim and Suit Cooperation

In the event of a claim under this Policy, the **Policyholder**, the **Insured Person** or the beneficiary, if applicable, must fully cooperate with **Us** in **Our** handling of the claim, including, but not limited to, the timely submission of all medical and other reports, and full cooperation with all physical examinations and autopsies that **We** may require. If **We** are sued in connection with a claim under this Policy, then the **Policyholder**, the **Insured Person** or the beneficiary must fully cooperate with **Us** in the handling of such suit. The **Policyholder**, the **Insured Person** or the beneficiary must not, except at their own expense, voluntarily make any payment or assume any obligation in connection with any suit without **Our** prior written consent.

[Coordination of Benefits

This Coordination of Benefits (“COB”) provision applies to **This Plan** when an **Insured Person** has health care coverage under more than one **Plan**. For the purposed of this COB provision, the following definitions apply:

- 1) **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more **Plans** covering the person for whom the claim is made.

The difference between the cost of a private **Hospital** room and the cost of a semi-private **Hospital** room is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is necessary either in terms of generally accepted medical practice or as specifically defined in the **Plan**.

When a **Plan** provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an **Allowable Expense** and a benefit paid.

- 2) **Claim Determination Period** means a calendar year. However, it does not include any part of a year during which a person has no coverage under **This Plan** or any part of a year before the date this COB provision or a similar provision takes effect.
- 3) **Plan** means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
 - (A) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (B) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under **Medicaid** (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (i) or (ii) is a separate **Plan**. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate **Plan**.

- 4) **Primary Plan/Secondary Plan**. The order of benefit determination rules state whether **This Plan** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person.

When **This Plan** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When **This Plan** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When there are more than two **Plans** covering the person, **This Plan** may be a **Primary Plan** as to one or more other **Plans** and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

- 5) **This Plan** means the part of the group contract that provides benefits for health care expenses.

If this COB provision applies, the order of benefit determination rules will be looked at first. The rules determine whether the benefits of **This Plan** are determined before or after those of another **Plan**. The benefits of **This Plan**:

- 1) will not be reduced when, under the order of benefit determination rules, **This Plan** determines its benefits before another **Plan**; but
- 2) may be reduced when, under the order of benefit determination rules, another **Plan** determines its benefits first.

Order of Benefit Determination Rules

- 1) General: When there is a basis for a claim under **This Plan** and another **Plan**, **This Plan** is a **Secondary Plan** which has its benefits determined after those of the other **Plan**, unless:

- (A) the other **Plan** has rules coordinating its benefits with those of **This Plan**; and
- (B) both those rules and **This Plan's** rules described below require that **This Plan's** benefits be determined before those of the other **Plan**.

- 2) Rules: This plan determines its order of benefits using the first of the following rules:

- (A) **Non-dependent/Dependent:** The benefits of the **Plan** which covers the person as an employee, member or subscriber are determined before those of the **Plan** which covers the person as a dependent of an employee, member or subscriber.
- (B) **Dependent Child/Parents Not Separated or Divorced:** Except as stated below, when **This Plan** and another **Plan** cover the same child as a dependent of different persons, called "parents":
 - (i) the benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year are determined before those of the **Plan** of the parent whose birthday falls later in that calendar year; but
 - (ii) if both parents have the same birthday, the benefits of the **Plan** which covered the parent longer are determined before those of the **Plan** which covered the other parent for a shorter period of time.

However, if the other **Plan** does not have this rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the **Plans** do not agree on the order of benefits, the rule in the other **Plan** will determine the order of benefits.

- (C) **Dependent Child/Separated or Divorced Parents:** If two or more **Plans** cover a person as a **Dependent Child** of divorced or separated parents, benefits for the child are determined in this order:

- (i) first, the **Plan** of the parent with custody of the child;
- (ii) then, the **Plan** of the **Spouse** of the parent with the custody of the child; and
- (iii) finally, the **Plan** of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents will be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' **Plans** have actual knowledge of those terms, benefits for the dependent child will be determined according to the rules above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the

benefits of the **Plan** of that parent has actual knowledge of those terms, the benefits of that **Plan** are determined first. This paragraph does not apply with respect to any **Claim Determination Period** or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- (D) Active/Inactive Employee: The benefits of a **Plan** which covers a person as an employee who is neither laid off nor retired or as that employee's **Dependent** are determined before those of a **Plan** which covers that person as a laid off or retired employee or as that employee's **Dependent**. If the other **Plan** does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (E) Continuation Coverage:
 - (i) If a person has continuation coverage under federal or state law and is also covered under another **Plan**, the following will determine the order of benefits:
 - (a) First, the benefits of a **Plan** covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.
 - (b) Second, the benefits under the continuation coverage.
 - (ii) If the other plan does not have the rule, and if, as a result, the plans do not agree on the order of benefits, this is ignored.
- (F) Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the **Plan** which covered an employee, member or subscriber longer are determined before those of the **Plan** which covered that person for the shorter time.

Effect on the Benefits of This Plan

- 1) **When This Section Applies**: This Section applies when, in accordance with the Order of Benefit Determination Rules, **This Plan** is a **Secondary Plan** as to one or more other **Plans**. In that event the benefits of **This Plan** may be reduced under this section. Such other **Plan** or **Plans** are referred to as the other **Plans**.
- 2) **Reduction in This Plan's Benefits**: The benefits of **This Plan** will be reduced when the sum of the following exceeds the **Allowable Expenses** in a **Claim Determination Period**:
 - (A) the benefits that would be payable for the **Allowable Expenses** under **This Plan** in the absence of this COB provision; and
 - (B) the benefits that would be payable for the **Allowable Expenses** under the other **Plans**, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of **This Plan** will be reduced so that they and the benefits payable under the other **Plans** do not total more than those **Allowable Expenses**.

When the benefits of **This Plan** are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of **This Plan**.

Right to Receive and Release Needed Information

We have the right to decide the facts We needs to apply these COB rules. We may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under **This Plan** must give the Us any facts We need to pay the claim.

Facility of Payment

A payment made under another **Plan** may include an amount which should have been paid under **This Plan**. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under **This Plan**. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, We may recover the excess from one or more of:

- 1) the persons it has paid or for whom it has paid;
- 2) insurance companies; or
- 3) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.]

Entire Contract and Application

This Policy, the **Policyholder's** application and the **Insured Person's** application, if any, together with the endorsements attached to this Policy, constitute the entire contract of insurance. If an application is completed by the **Policyholder** or **Insured Person** in connection with this Policy, then **We** will attach the application to the Policy when the Policy is issued.

Examination Under Oath

We have a right to examine under oath, as often as **We** may reasonably require, an **Insured Person**, the **Policyholder** or the beneficiary. **We** may also require the **Insured Person**, the **Policyholder** or the beneficiary to provide a signed description of the circumstances surrounding the **Loss, Accident** or **Sickness** and their interest in the **Loss, Accident** or **Sickness**. An **Insured Person**, the **Policyholder** and the beneficiary will also produce all records and documents requested by **Us** and will permit **Us** to make copies of such records or documents.

Governing Jurisdiction and Conformance With Statutes

This Policy is governed by the laws of the jurisdiction in which it is delivered to the **Policyholder**. Any terms of this Policy which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which this Policy is delivered are amended to conform to such statutes, laws or regulations.

Grace Period

The **Policyholder** is entitled to a grace period of thirty-one (31) days from the premium due date for the payment of premium due. This policy will continue in force during the grace period. The grace period does not apply to the first premium payable during this policy term. Failure to pay the first premium on or before the due date will immediately terminate this policy as of inception. **We** are not required to provide notification of such termination.

Inadvertent Error

The insurance provided under this Policy will not be prejudiced by the failure on the part of the **Policyholder** to transmit reports, collect and remit premium or comply with any of the terms and conditions of this Policy when such failure is due to an inadvertent error or clerical mistake, provided that such inadvertent error or clerical mistake is corrected promptly upon discovery.

An inadvertent error or clerical mistake by **Us** or by the **Policyholder** may be corrected upon discovery with notice by the **Policyholder** to **Us** or by **Us** to the **Policyholder**.

Informational and Advertising Material

The **Policyholder** and its representatives must gain **Our** prior written approval of all material used for advertising and solicitation relating to this Policy, regardless of the medium in which such material appears. **We** will not be responsible for any increase in payment or any changes in insurance resulting from such materials that have not been approved by **Us**.

Legal Action Against Us

No legal action may be brought to recover on this Policy until sixty (60) days after **We** have been given complete **Proof of Loss**. No such action may be brought after three (3) years from the time complete **Proof of Loss** is required to be given. No such action may be brought unless there has been full compliance with all of the terms of this Policy.

In no case will **We** be liable for benefits that are not payable under the terms of this Policy or that exceed the applicable Benefit Amounts or limits of insurance of this Policy.

Non-Renewal

This Policy is a non-renewable one year term policy. The Policy is issued for the Policy Period stated in the Insuring Agreement. If the **Policyholder** desires to continue coverage beyond the Policy Period stated, then **We** will issue a new Policy for the new Policy Period.

Physical Examination and Autopsy

We have the right to have an **Insured Person** examined by a **Physician** approved by **Us**, as often as reasonably necessary while a claim is open. **We** may also have an autopsy done by a **Physician**, unless prohibited by law. Any examinations or autopsies that **We** require will be done at **Our** expense.

Premium Payment

The **Policyholder** will collect and remit to **Us** all premium due under this Policy, subject to the grace period.

Premium is adjustable. The earned premium is calculated for each reporting period based on the applicable rates and exposures. The **Policyholder** must keep records of the information **We** need to calculate the premium and send **Us** copies of these records for each reporting period.

The earned premium will be computed on a [pro-rata] basis. Any unearned premium will be remitted to the **Policyholder** as soon as practicable.

Records and Audit

We may examine the **Policyholder's** books and records relating to this Policy at any reasonable time during the Policy term and up to three (3) years after expiration of this Policy or until final adjustment and settlement of all claims under this Policy, whichever is later.

The **Policyholder** must maintain information pertaining to **Insured Persons** including but not limited to each **Insured Person's** Benefit Amount and enrollment form, if any, and beneficiary designations or assignments.

Statements by Policyholder or Insured Person and Incontestability

We will not use any statements made by the **Policyholder** or the **Insured Person** to void the insurance or reduce benefits payable under this Policy, or to otherwise contest the validity of this Policy, unless such statements are contained in a written document signed by the **Policyholder** or the **Insured Person**. If **We** rely on such statements for this purpose, then **We** will provide a copy of the written document to the **Policyholder**, the **Insured Person** or the **Insured Person's** designee or beneficiary, as appropriate.

We will consider all statements made by the **Policyholder** and the **Insured Person** to be representations and not warranties.

We will not use statements made by the **Policyholder** or the **Insured Person** regarding insurability to contest the validity of this Policy when the statements are made more than two (2) years after this Policy has been in force during the **Insured Person's** lifetime.

Nothing in this section will preclude **Us** from asserting at any time defenses based upon a claimant's ineligibility for insurance under this Policy or upon any other Policy provision or condition.

Titles of Paragraphs

The titles of the various paragraphs of this Policy and any endorsements attached to this Policy are inserted solely for convenience of reference and do not limit or affect in any way the provisions to which they relate.

Utilization Review

There is no utilization review performed on this policy.

Workers' Compensation

The benefits payable under this Policy are not in lieu of and do not affect any requirement for workers' compensation insurance.