

SERFF Tracking Number: HMRK-126907796 State: Arkansas
 Filing Company: HM Life Insurance Company State Tracking Number: 47342
 Company Tracking Number: HM207-SI GP 1010
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Student Accident & Sickness
 Project Name/Number: Student Short Term Filing/HM207-SI GP (10/10)

Filing at a Glance

Company: HM Life Insurance Company

Product Name: Student Accident & Sickness

TOI: H04 Health - Blanket Accident/Sickness

Sub-TOI: H04.001 Student

Filing Type: Form

SERFF Tr Num: HMRK-126907796 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47342

Co Tr Num: HM207-SI GP 1010

Author: Jennifer Bayich

Date Submitted: 11/18/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 11/23/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Student Short Term Filing

Project Number: HM207-SI GP (10/10)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/23/2010

Deemer Date:

Submitted By: Jennifer Bayich

PPACA: Not PPACA-Related

Filing Description:

Enclosed for filing with your department are the above-captioned forms. When approved, Policy Form Series HM207-SI GP (10/10), et al. will replace existing business issued on the following forms, at the next renewal following the date of approval:

Form	Approved	Filing Number
Form HM207-SI GP	04/30/2007	HMRK-125143904

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Exempt from filing
in Pennsylvania.

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association

Explanation for Other Group Market Type:

State Status Changed: 11/23/2010

Created By: Jennifer Bayich

Corresponding Filing Tracking Number:
HM207-SI GP (10/10)

SERFF Tracking Number: HMRK-126907796 State: Arkansas
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 Form HM207-SI GC 04/30/2007 HMRK-125143904

The attached forms will also be used for new business issued after the date of approval. The following forms will continue to be used with HM207-SI GP (10/10), et. al.

Form	Approved	Filing Number
HM207-SI (AR)	04/30/2007	HMRK-125143904
HM207-SI-E(AR)(07/09)	08/05/09	HMRK-126249554

A "red-lined" copy and clean copy of the referenced forms is enclosed. In the "red-lined" copy:

- Provisions and text that have been deleted are struck through;
- New, changed or additional text is underlined in red.

The clean copy contains clear text. Optional limits, wording or provisions are bracketed –

[] Bold Brackets indicate that this section within brackets may be included or excluded.

[] Brackets in regular print indicate that this sentence, clause, or word may be included or excluded.

{ / } Bold Brackets with a / indicate that in the construction of the certificate that the writer may choose among the options presented within the Bold Brackets. The / indicates that one choice has ended and a new one is about to begin.

{ / } Brackets of this type in regular print indicate choices within sections of the { / }.

<# - #> Brackets of this type provide a range of numbers within which the writer of the policy must choose a number for the particular certificate.

<#> Brackets with a single number, letter, or "Section 3" simply indicate that the next number, letter, or Section # in sequence should occur. They will vary according to the variables chosen.

In order to accommodate our policyholders' specific needs, we request that these forms be approved as variable on a general-use basis. You have our assurance we will not add to or revise any language, but only remove language in the manner described in the memorandum. Any variability will be administered within your state's requirements. To the best of my knowledge, the forms comply with all of your applicable statutes.

The Policy will be issued directly to educational institutions or associations sponsoring educational activities. It is

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primarily designed to provide short term coverage to individuals engaged in educational activities outside of the participant's home country. All individuals enrolled in or associated with a participating education institution or an association sponsoring educational activities may participate in the program. To obtain coverage an individual must:

- Be enrolled in or associated with an educational institution or an association sponsoring educational activities; and
- Intend to pursue an educational activity outside his or her home country; and
- Enroll prior to leaving for his or her "country of assignment".

For foreign nationals the "country of assignment" is the United States - for citizens or residents of the United States the "country of assignment" is any foreign country.

Coverage ends at the earlier of:

- The last day of the educational institutions school year; or
- The date the individual returns to his or her Home Country; or
- 364 days from the individual effective date of coverage.

Should you have any questions or concerns, please do not hesitate to contact me. I may be reached directly at the left-side address, as well as via telephone at 412-544-0923, or via e-mail to jennifer.bayich@hminsurancegroup.com.

Thank you for your time and attention to this matter.

Sincerely,
Jennifer L. Bayich, Esq.
Compliance Analyst III

Company and Contact

Filing Contact Information

Jennifer Bayich, Compliance Analyst II jennifer.bayich@hminsurancegroup.com
P.O. Box 535061 412-544-0923 [Phone]
P6504 412-544-1138 [FAX]
Pittsburgh, PA 15235-5061

Filing Company Information

HM Life Insurance Company CoCode: 93440 State of Domicile: Pennsylvania
PO Box 535065 Group Code: 812 Company Type:
Suite P6504 Group Name: HM Insurance Group State ID Number:
Pittsburgh, PA 15253-5065 FEIN Number: 06-1041332

SERFF Tracking Number: HMRK-126907796 State: Arkansas
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Product Name: Student Accident & Sickness
Project Name/Number: Student Short Term Filing/HM207-SI GP (10/10)
(412) 544-1139 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: 2 forms x \$50 = \$100
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HM Life Insurance Company	\$100.00	11/18/2010	42054177

SERFF Tracking Number: HMRK-126907796 State: Arkansas
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Product Name: Student Accident & Sickness
Project Name/Number: Student Short Term Filing/HM207-SI GP (10/10)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/23/2010	11/23/2010

SERFF Tracking Number: *HMRK-126907796* *State:* *Arkansas*
Filing Company: *HM Life Insurance Company* *State Tracking Number:* *47342*
Company Tracking Number: *HM207-SI GP 1010*
TOI: *H04 Health - Blanket Accident/Sickness* *Sub-TOI:* *H04.001 Student*
Product Name: *Student Accident & Sickness*
Project Name/Number: *Student Short Term Filing/HM207-SI GP (10/10)*

Disposition

Disposition Date: 11/23/2010

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
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document	Red-Lined Policy	Approved-Closed	Yes
Supporting Document	Red-Lined Certificate	Approved-Closed	Yes
Form	Blanket Insurance Policy	Approved-Closed	Yes
Form	Blanket Short Term Student Accident and Sickness Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number: HM207-SI GP 1010

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/23/2010	HM207-SI GP (10/10)	Policy/Cont ract/Fratern al Certificate	Blanket Insurance Policy	Initial		52.000	Student Policy HM207-SI GP (10-10).pdf
Approved-Closed 11/23/2010	HM207-SI GC (10/10)	Certificate	Blanket Short Term Student Accident and Sickness Insurance	Initial		52.000	Short Term Student Certificate HM1207-SI GC (10- 10).pdf

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

1-800-328-5433

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

POLICYHOLDER: [Specimen] (the “Participating Organization or Institution”)

POLICY EFFECTIVE DATE: <###>

POLICY NUMBER: <###> (“the Policy”)

STATE OF DELIVERY: [State]

ADMINISTRATOR: [ABC Administrator]

This Policy is a legal contract between the Policyholder and **HM Life Insurance Company** (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGREEMENT

This Policy, the Certificates issued under the policy, the application of the Policyholder form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by a Covered Person, by the Insurer’s Agent, or by any other person are not part of this Policy. Only the Insurer’s President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Covered Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

POLICY TERM

Policy Effective Date: <###>

Policy Termination Date: The Policy will continue in force while the required premiums are paid until the Policy is terminated by either the Policyholder or by the Insurer. At least <31 – 90> days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Participating Organization’s or Institution’s coverage under the Policy may be canceled at any time after <31 – 90> days written notice mailed or delivered by the Insurer to the Participating Organization or Institution or by the Participating Organization or Institution to the Insurer.

If the Insurer cancels the coverage under Policy, the Insurer will mail or deliver the written notice to the Participating Organization or Institution at the last address stated in the Insurer’s records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the <32nd – 91st day after the Insurer mails or delivers the written notice.

If the Participating Organization or Institution cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

If the Participating Organization or Institution or the Insurer cancels the coverage under the Policy, the Covered Person’s coverage will continue through the end of his/her Period of Coverage, provided the Insurer has received the applicable premium.

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Covered Person’s Period of Coverage. No benefit is payable for charges incurred after the effective date of the cancellation of coverage under the Policy, except as provided in the Policy’s benefit provisions.

[Cancellation of Covered Person's Coverage: A Covered Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.]

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly or semi-annually for the entire Policy Term, or for a specified time period less than 364 days. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Covered Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect. "Policy Terms" are successive 12 month periods beginning on the Policy Effective Date.

Premium Due Dates: The Covered Person's first premium is due and payable on the Covered Person's Period of Coverage Effective Date.

Change in Premium: {The Insurer may change the premiums due by giving written notice of such change at least <31 – 90> days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended.

If the Insurer changes rates during a Policy Term, the change will apply only to a Periods of Coverage starting on or after the effective date of the change. The Insurer will give the Participating Organization or Institution at least 31 days advance written notice of any change.} [The Insurer will not change rates during the initial PolicyTerm.]

[Renewing Coverage: The Participating Organization or Institution may renew the coverage provided by the Policy for another Policy Term by completing an acceptable renewal form. Renewal is subject to the Insurer's written approval and receipt of premium prior to the end of the current Policy Term. There is a 31 day grace period in which to pay the premium due. The Insurer further reserves the right to re-determine the premium rate at the end of any Policy Term. [Renewals may be subject to a minimum premium payment.]]

[Group, Full Cancellation: If the Administrator accepts the request for cancellation and the cancellation occurs within 180 days of the effective date, a full refund will be given if there are no claims filed or paid. Cancellation is not effective until the beginning of the month after which claims have been filed. If the cancellation occurs 180 days or more after the effective date, a refund will not be given. Exceptions are not granted if notice is received after 180 days or more. Calculation of 180 days via web or fax is the date submitted or faxed. Calculation of 180 days via paper is the postmark date.]

[Group, Partial Cancellation: All premium is earned within 180 days from date of enrollment of a Covered Person if there are no claims filed or paid. If there are claims, all premium is earned. If there are no claims, the refund is based upon the following:

Length of Time from Enrollment Date	Premium Earned	Percent Refund
0-60 days	0%	100%
61-120 days	50%	50%
121-180	80%	20%
181 days or more	100%	0%]

[Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator.]

[Cancellation Requirements: Cancellation will only be allowed if one of the following three requirements are met:

1. proof of ineligibility is provided;
2. claims have not been submitted; or
3. cancellation occurs within the first 60 days from the effective date or most recent renewal date.

A full refund will be given. [A \$50 administration fee deducted from the premium will be charged. If cancellation is after 60 days, 100% of the premium is earned and a refund will not be given.]]

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of **HM Life Insurance Company**.

A handwritten signature in cursive script that reads "Mike Sullivan". The signature is written in dark ink on a light background.

President

**BLANKET INSURANCE POLICY
PROVIDING STUDENT ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable**

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

CERTIFICATE OF COVERAGE

BLANKET SHORT TERM STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. [###] (“the Policy”)

Participating Organization or Institution:	[DEF Organization /GHI Institution]
Participating Organization’s or Institution’s Effective Date:	<JANUARY 1, 20XX>
Eligible Participant:	See Identification Card Issued to Participant
[Eligible Dependents:	See Identification Card Issued to Participant]
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant [and an Eligible Dependent] as a “Covered Person,” and to **HM Life Insurance Company** as “Insurer.” The Policy will be administered on behalf of the Insurer by the Administrator:” Worldwide Insurance Services, Inc., aka “HTH Worldwide”.

The benefits provided by this Certificate terminate at the end of the current Period of Coverage.

At the beginning of the next Period of Coverage an Eligible Participant may re-apply for his / her coverage. Any re-application is subject to the Insurer’s approval and payment of any applicable premium by the Eligible Participant to the Insurer. Premiums will be based upon the attained age of the Covered Person at the beginning of the Period of Coverage.



President

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**SECTION 1
SCHEDULE OF BENEFITS**

ELIGIBLE CLASSES

[The Classes eligible for coverages available under the Policy are shown below. [The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.]]

- [___] Class I: Regular, full-time Eligible International Participants of the [educational] organization or institution enrolled in at least <4 – 16> hours [and their Eligible Dependents].]
- [___] Class II: Part-time Eligible International Participants of the [educational] organization or institution [and their Eligible Dependents].]
- [___] Class III: [Mandatory] [Voluntary] - Eligible International Participants.]
- [___] Class IV: Voluntary - Eligible International Dependents - Spouse.]
- [___] Class V: Voluntary - Eligible International Dependents - Child.]
- [___] Class VI: Study Abroad Student Eligible Participants enrolled in the educational institution’s sponsored or approved study abroad program [and their Eligible Dependents].]
- [___] Class VII Study Abroad Staff Eligible Participants providing direct support to the educational institution’s sponsored or approved study abroad program at its Country of Assignment location [and their Eligible Dependents].]

All benefits and limits are stated per Covered Person

TABLE 1

	Limits Eligible Participant	Limits [Spouse / Dependent]	Limits Child
[COVERAGE A--MEDICAL EXPENSES			
[Period of Coverage Maximum Benefits	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>]
[Maximum Benefit per Injury or Sicknesses	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>]
[Basic Medical Expense Benefit [per Injury or Sickness / per -Period of Coverage]	Up to <\$0 - \$1,000,000> Maximum: <50% - 100%> of Reasonable Expenses after Deductible.	Up to <\$0 – 1,000,000> Maximum: <50% - 100%> of Reasonable Expenses after Deductible.	[Up to <\$0 - \$1,000,000> Maximum: <50% - 100%> of Reasonable Expenses after Deductible.]
[Supplemental Major Medical Expense Benefit (SMM) [per Injury or Sickness / per Period of Coverage]	After Basic Medical Expense Benefit Maximum has been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum	After Basic Medical Expense Benefit Maximum has been paid, , <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum	After Basic Medical Expense Benefit Maximum has been paid, , <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum]

TABLE 1 (Continued)

[Catastrophic Major Medical Expense Benefit (CMM) [per Injury or Sickness / per Period of Coverage]	After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum	After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum	[After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum]
[Pregnancy coverage	Reasonable Expenses [up to <\$100 - \$25,000>] Maximum per Period of Coverage	Reasonable Expenses [up to <\$100 - \$25,000>] Maximum per Period of Coverage	Reasonable Expenses [up to <\$100 - \$25,000>] Maximum per Period of Coverage]
[Deductible. [(Deductible is reduced to <\$0 - \$50> if treatment is received at Recognized Student Health Center or if initial treatment is received at Recognized Student Health Center.)]	[<\$0 - \$5,000> per Injury or Sickness [and limited to <\$100 - \$5,000> per Policy Year] / <\$0 - \$5,000> per Period of Coverage per Covered Person [and limited to <\$100 - \$5,000> per Family per Period of Coverage]]	[<\$0 - \$5,000> per Injury or Sickness [and limited to <\$100 - \$5,000> per Policy Year] / <\$0 - \$5,000> per Period of Coverage per Covered Person [and limited to <\$100 - \$5,000> per Family per Period of Coverage]]	[<\$0 - \$5,000> per Injury or Sickness [and limited to <\$100 - \$5,000> per Policy Year] / <\$0 - \$5,000> per Period of Coverage per Covered Person [and limited to <\$100 - \$5,000> per Family per Period of Coverage]]
[[Period of Coverage / Maximum] Out-of-Pocket Limit [for any one Injury or Sickness]	After the Covered Person reaches a <\$100 – \$10,000> Out-of-Pocket Limit [per Injury or Sickness] [per Period of Coverage], the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit.	After the Covered Person reaches a <\$100 – \$10,000> Out-of-Pocket Limit [per Injury or Sickness] [per Period of Coverage], the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit	After the Covered Person reaches a <\$100 – \$10,000> Out-of-Pocket Limit [per Injury or Sickness] [per Period of Coverage], the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit]
Out-of-Pocket Limit means the amount of Reasonable Expenses for which the Covered Person is responsible after which the Insurer pays 100% of the Reasonable Expenses, subject to the limits and provisions of the Policy.]			
[COVERAGE B-- ACCIDENTAL, DEATH AND DISMEMBERMENT	<p align="center">Limits Eligible Participant</p> Maximum Benefit Principal Sum up to <\$500 - \$100,000>	<p align="center">Limits [Spouse / Dependent]</p> Maximum Benefit Principal Sum up to <\$500 - \$100,000>	<p align="center">Limits Child</p> Maximum Benefit Principal Sum up to <\$500 - \$100,000>]
[COVERAGE C REPATRIATION OF REMAINS	Maximum Benefit up to <\$1,000 - \$100,000>	Maximum Benefit up to <\$1,000 - \$100,000>	Maximum Benefit up to <\$1,000 - \$100,000>]
[COVERAGE D MEDICAL EVACUATION	[Maximum Benefit for all Evacuations up to <\$10,000 - \$1,000,000>/ Reasonable Cost of the Evacuation as determined by the Insurer]	[Maximum Benefit for all Evacuations up to <\$10,000 - \$1,000,000>/ Reasonable Cost of the Evacuation as determined by the Insurer]	[Maximum Benefit for all Evacuations up to <\$10,000 - \$1,000,000>/ Reasonable Cost of the Evacuation as determined by the Insurer]]

TABLE 1 (Continued)

**[COVERAGE E
Bedside Visit**

Up to a maximum benefit of <\$500 - \$5,000> for the [cost / purchase] of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person

Up to a maximum benefit of <\$500 - \$5,000> for the [cost / purchase] of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person

Up to a maximum benefit of <\$500 - \$5,000> for the [cost / purchase] of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person]

TABLE 2

COVERAGE A--MEDICAL EXPENSES	[Indemnity Plan Limits	[PPO Plan In PPO Limits+	[PPO Plan Outside PPO Limits
[Physician Office Visits[*]]	[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible[/ and / or / and/or] <\$5 - \$200> Copayment per visit].]]	[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]	[[[For Basic,] [After Deductible], <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]
[Inpatient Hospital Services [not including Emergency Hospital Services]	[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]]	[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible[/ and / or / and/or] <\$5 - \$200> Copayment per visit]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]	[[[For Basic,] [After Deductible], <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]
[Maximum payment for all Hospital Services delivered in association with semi-private accommodations up to <\$200 - \$2,000> per day.]			
[Maximum payment for all Hospital Services delivered in association with care in an Intensive Care Facility up to <\$200 - \$3,000> per day.]			
[Hospital and Physician Outpatient Services]	[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]]	[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]	[[[For Basic,] [After Deductible], <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]
[Maximum payment for all Hospital and Physician Outpatient Services delivered in association with [an Injury or a Sickness / each diagnosis] is limited to <\$200 - \$10,000> per [Injury or Sickness / each diagnosis].]			

**[Hospital and Physician
Outpatient Services]**

[Maximum payment for all Hospital and Physician Outpatient Services delivered in association with [an Injury or a Sickness / each diagnosis] is limited to <\$200 - \$10,000> per [Injury or Sickness / each diagnosis].]

[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit].]]

[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]

[[[For Basic,] [After Deductible,] <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]

COVERAGE A--MEDICAL EXPENSES

[Indemnity Plan Limits

[PPO Plan In PPO Limits

[PPO Plan Outside PPO Limits

[Emergency Hospital Services]

<50% - 100%> of Reasonable Expenses [after Deductible] [and after <\$50 - \$500> Copayment per visit]. [If admitted to Hospital, then <50% - 100%> of Copayment Waived.]

<50% - 100%> of Reasonable Expenses [after Deductible] [and after <\$50 - \$500> Copayment per visit]. [If admitted to Hospital, then <50% - 100%> of Copayment Waived.]

<50% - 100%> of Reasonable Expenses [after Deductible] [and after <\$50 - \$500> Copayment per visit]. [If admitted to Hospital, then <50% - 100%> of Copayment Waived.]

[+Payment of Covered Medical Expenses for Preferred Providers is based on the Insurer's negotiated rate. Preferred Providers have agreed to accept the negotiated rate as payment in full.]

[[[*All / <50% - 75%>] Physician Visit Copayments / [*All / <50% - 75%>] of Deductibles] [for an Injury or Sickness] are waived if treatment is received at Recognized Student Health Center or if the initial treatment for an Injury or Sickness is received at Recognized Student Health Center.]

If a Covered Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

[If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Preferred Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Preferred Provider.]

**TABLE 3
COVERAGE A--MEDICAL EXPENSE BENEFITS**

BENEFITS LISTED BELOW ARE SUBJECT TO

- 1. **TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;**
- <#.> **[TABLE 1 LEVELS OF COVERAGE FOR BASIC MEDICAL EXPENSE BENEFITS, SUPPLEMENTAL MAJOR MEDICAL EXPENSE BENEFITS, AND CATASTROPHIC MAJOR MEDICAL EXPENSE BENEFITS; [AND]]**
- <#.> **[TABLE 2 PLAN TYPE LIMITS (INDEMNITY OR PPO)]**

MEDICAL EXPENSES

Eligible Participant and Dependent

[Maternity Care for a Covered Pregnancy

Reasonable Expenses [with <\$100 - \$10,000 Copayment for the delivery of the child of a Covered Pregnancy.] [Conception must have occurred while the Covered Person was insured under the Policy.]

[Inpatient treatment of mental and nervous disorders [including drug or alcohol abuse]	Reasonable Expenses up to <\$500 - \$25,000> [Maximum per Period of Coverage] [for a maximum period of <30 – 100> days per Period of Coverage .]
[Outpatient treatment of mental and nervous disorders [including drug or alcohol abuse]	Reasonable Expenses up to <\$500 - \$25,000> Maximum per Period of Coverage.]
[Treatment of drug and alcohol abuse]	[Reasonable Expenses up to <\$500 - \$25,000> Maximum per Period of Coverage.] [Included in coverage for Inpatient and Outpatient mental and nervous disorders.] / Maximum of <10 – 100> visits per <6 – 24> month period [and a maximum of <\$25 - \$100> per visit. [<Ten – Thirty> of such visits may be for the benefit of the immediate family].]
[Inpatient and Outpatient treatment of mental and nervous disorders [including drug or alcohol abuse]	Reasonable Expenses up to <\$500 - \$25,000> Maximum per Period of Coverage]
[Outpatient back and spine treatment (including modalities)	Reasonable Expenses up to <\$250 - \$10,000> Maximum per Period of Coverage with a <\$25 - \$200> per visit Maximum and a Maximum of <1 – 5> visits per week]
[Treatment of specified therapies, including acupuncture and Physiotherapy]	[Reasonable Expenses up to <\$500 - \$10,000> Maximum per [Period of Coverage / Injury or Sickness] on an Inpatient basis / Reasonable Expenses for up to <20 – 60> days Maximum per [Period of Coverage / Injury or Sickness] on an Inpatient basis. / Reasonable Expenses up to <\$500 - \$10,000> Maximum per [Period of Coverage / Injury or Sickness] on an Outpatient basis / Reasonable Expenses up to <\$25 - \$100> Maximum per visit subject to a Maximum of <10 – 100> visits [on an Outpatient basis] [if service is prescribed by a Physician and such prescription is for a stated number of visits.] This benefit is per [Period of Coverage / Injury or Sickness. / Reasonable Expenses up to <\$500 - \$10,000> Maximum combined total for Inpatient and Outpatient care, up to <10 – 100> days immediately following the attending Physician’s release for rehabilitation following a covered Hospital confinement or surgery per [Period of Coverage / Injury or Sickness.]]
[[Therapeutic termination of pregnancy] [Elective termination of pregnancy]	Reasonable Expenses up to <\$100 - \$1,000> [In PPO] Maximum per Period of Coverage [and up to <\$100 - \$1,000> [Outside PPO] Maximum per Period of Coverage]]
[Routine nursery care of a newborn child of a covered pregnancy]	Reasonable Expenses up to <\$250 - \$2,000> Maximum per Period of Coverage]
[Treatment of Congenital Conditions and conditions arising or resulting directly therefrom]	[Reasonable Expenses. / Reasonable Expenses up to <\$1,000 - \$25,000> Maximum per Period of Coverage]]
[Annual cervical cytology screening for women 18 and older]	<50% - 100%> [of] [Reasonable Expenses].]
[Low dose mammography screening[, one baseline mammogram and one mammogram per year].]	<50% - 100%> [of] [Reasonable Expenses].]
[Medical treatment arising from participation in [intercollegiate,] [interscholastic][, intramural] [,club] or [professional] sports]	Reasonable Expenses up to <\$1,000 - \$100,000> Maximum per [Period of Coverage / Injury or Sickness] [Injuries from participation in intramural sports are covered as any other Injury]

TABLE 3 – (Continued)

[Outpatient Laboratory Tests and Xrays]	[Limited to a maximum of <\$100 - \$2,500 per [Injury or Sickness / Period of Coverage].]
[CAT Scans and MRI's]	[Reasonable Expenses Limited to a maximum of <\$100 - \$2,500 per [Injury or Sickness / Period of Coverage].]
[Vaccinations required by Participating Organization or Institution]	<50% - 100%> [of] [Reasonable Expenses.]]
[Medical treatment of Injuries sustained as a result of a covered motor vehicle accident]	Reasonable Expenses [up to <\$500 - \$100,000> Maximum per [Period of Coverage / Injury or Sickness]]
[Repairs to sound, natural teeth required due to an Injury]	<50% - 100%> of Reasonable Expenses up to <\$50 – \$2,500> per Period of Coverage maximum/<\$50 – 300> per tooth]
[Dental Treatment (including extractions) to alleviate pain]	<50% - 100%> of Reasonable Expenses up to <\$50 - \$500> per Period of Coverage]
[Repair or replacement of an existing prosthetic device]	<50% - 100%> of Reasonable Expenses up to <\$50 - \$1,000>. [Not Available in Home Country.]]
[Outpatient prescription drugs filled at Student Health Center]	[<50% - 100%> of actual charge [after a <\$5 - \$30> Copayment per prescription] / No Charge].]
[Outpatient prescription contraceptives and devices filled at Student Health Center]	[<50% - 100%> of actual charge [after a <\$5 - \$30> Copayment per prescription] / No Charge].]
[Outpatient prescription drugs]	[<50% - 100%> of actual charge / Not Covered. / Prescription Drug Program with the Copayment stated below], [up to a maximum of <\$100 - \$5,000> per Period of Coverage].[Limited to a 31 day supply for initial fill or refill.]]
1. Generic Drugs	All except a <\$5 - \$50> Copayment per prescription
2. Brand Name Drugs	All except a <\$5 - \$50> Copayment per prescription]
3. Injectables	All except a <\$5 - \$50> Copayment per prescription]
[Outpatient prescription contraceptives and devices]	Covered under prescription drugs benefit above [and limited to no more than <\$100 - \$1,000> per Period of Coverage.]
[Professional ground [or air ambulance] service to nearest hospital]	Reasonable Expenses [up to <\$100 - \$2,000> per Injury or Sickness]]
[Preventive and primary care services]	Reasonable Expenses for unlimited visits for children up to the age of 12 years and Reasonable Expenses for 3 visits per year for minor children ages 12 years up to 18 years of age.]
[Medical treatment received in the Home Country [, if NOT covered by Other Plan]	<50% - 100%> of Reasonable Expenses up to a maximum of <\$250 - \$10,000>]
[Certain Pre-existing Conditions and Diseases will be considered Covered Sickness from the Effective Date of Coverage]	A maximum of <\$100 - \$2,000] per [Period of Coverage / Injury or Sickness] will be paid for all medical treatment the following conditions and diseases: malaria, dysentery, tuberculosis, cholera, shigellosis, typhoid fever, typhus, diphtheria, yellow fever, schistosomiasis, and mosquito borne encephalitis.]

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A--MEDICAL EXPENSES

- A. What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable [for any one Injury or Sickness] will not exceed the Maximum Benefit for the Eligible Participant [or the Maximum Benefit for an Eligible Dependent] stated in Coverage A—Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Copayments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, [the Recognized Student Health Center provision] and to all other limitations and provisions of the Policy.
- B. Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group policy administered by the Administrator immediately prior to the Coverage Start Date shown on the Identification Card issued to the Participant, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance.

1. Physician office visits.

- 2. Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

If Tests and Xrays are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services there is no additional Copayment for these Tests or Xrays. [A Deductible may apply.] However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

- <3.> Emergency Hospital Services.** Emergency Hospital Services are Emergency Medical Care delivered in a Hospital emergency room as defined in this Policy. If there is no admission to the Hospital, there will be a Copayment as stated in the Schedule of Benefits.

<4.> [Recognized Student Health Centers:

[The Policy does not cover the cost of treatment or services that are [provided normally without charge by Policyholder' Student Health Center][, covered or provided by the student health fee,] [rendered by an person employed by the Policyholder, including team Doctor and trainers] [or any other service performed at no cost.] No premium charged is charged for any such treatment.]

[If there is a charge for visits to, or medical services, treatments and supplies received from, a Recognized Student Health Center for an Injury or a Sickness, benefits for those visits, medical services, treatments and supplies will be paid at <50% - 100%> of Reasonable Expenses with no Copayment or Deductible.]

[[If the Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a provider (if available) included on the Administrator's list provided to the Recognized Student Health Center. / If the

Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a Preferred Provider. If the Covered Person uses the Preferred Provider, medical benefits are paid according to the "Inside PPO" schedule. If the Covered Person chooses not to use the Preferred Provider, medical benefits are paid according to the "Outside PPO" schedule.] [The Copayment and/or Deductible for the initial visit to the Preferred Provider will be waived or reduced if seen by the Recognized Student Health Center first. See Table 2 of the Schedule of Benefits.]]

[C. **Additional Covered General Medical Expenses and Limitations:** These additional Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

<1.> **[Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. [Conception must have occurred while the Covered Person was insured under the Policy.] Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a. A minimum of 48 hours of inpatient care following a vaginal delivery; or
- b. A minimum of 96 hours of inpatient care following delivery by cesarean section.

If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a. Parental education;
- b. Assistance and training in breast or bottle feeding; and
- c. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.]

<2.> **[Annual cervical cytology screening for cervical cancer and its precursor states for women [age 18 and older]:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear. [(Cervical screenings are not subject to the deductible provision)].

<3.> **[Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:

- a. Female Covered Persons are allowed one baseline mammogram;
- b. Female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.);]

<4.> **[Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.]

<5.> **[Diabetic Supplies/Education:** Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.]

<6.> **[Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.]

<7.> **[Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic

screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.]

<8.> **[Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:

- a. Reconstruction of the breast on which the mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- c. Prostheses; and
- d. Treatment for physical complications of all stages of mastectomy, including lymphedemas.]

<9.> **[Hormone Replacement Therapy:** If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.]

<D.> **[Basic Medical Expense Benefit (Basic):** The Insurer will pay the provider <50% - 100%> of all Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A. [The Basic Medical Expense Deductible Amount will be reduced to as stated in the Schedule of Benefits if initial treatment is rendered at the Participant's Registered Student Health Center.]]

<E.> **[Supplemental Major Medical Expense Benefit (SMM):** The Insurer will pay the provider <50% - 100%> of all additional Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A and after all benefits have been exhausted under the Basic Medical Expense Benefit.]

<F.> **[Catastrophic Major Medical Expense Benefit (CMM):** The Insurer will pay the provider <50% - 100%> of all Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A and after all benefits have been exhausted under the Basic Medical Expense Benefit and Supplemental Major Medical Expense Benefit.]

<G.> **[Home Country Coverage (While Insured):** Expenses incurred within the Covered Person's Home Country while insured under the Policy will be considered as Covered Medical Expenses up to the limits stated in the Schedule of Benefits.]

<H.> **[[Home Country Coverage (Conditions First Diagnosed or Treated in the Country of Assignment) (Mandatory Only):** Expenses incurred within the Covered Person's Home Country, while insured under the Policy, for conditions first diagnosed or treated in the Country of Assignment will be considered as Covered Medical Expenses up to <\$500 - \$25,000>.]

[Expenses incurred within the Covered Person's Home Country while insured under the Policy will be considered as Covered Medical Expenses when:

1. They are Medically Necessary and are authorized after the Covered Person has proven Sickness or Injury in the Country of Assignment; or
2. They are related to a pre-approved medical evacuation and would have been covered had the expenses been incurred in the Country of Assignment.]

[The Covered Person will continue to be covered under the Policy's Medical Treatment Benefits provision during temporary return visits to his/her Home Country. However, the Home Country medical expense coverage is limited to <\$500 - \$25,000> per [Injury or Sickness [and for a maximum accumulation of <30 - 90> days of return visits to the Home Country during the Period of Coverage].

[[All medical expenses incurred in the Home Country are subject to a <\$50 - \$1,000> Deductible.] [After satisfying the Deductible,] the Insurer will pay <50% - 100%> of Reasonable Expenses incurred up to <\$500 - \$25,000> per [Injury or Sickness / Period of Coverage]. [Then, the Insurer will pay <50% - 100%> of Reasonable Expenses incurred up to an additional <\$500 - \$50,000> per [Injury or Sickness / Period of Coverage].] [Thereafter, the Insurer will pay <50% - 100%> of Reasonable Expenses incurred up to an additional <\$500 - \$250,000> per [Injury or Sickness / Period of Coverage].]]

The Insurer will not cover any medical expense incurred in the Home Country after the Home Country medical expense coverage limits described above have been exceeded.

Payment is subject to the Limitations and Conditions on Eligibility for Benefits provision.]

<SECTION 3>
[DESCRIPTION OF COVERAGES
[[COVERAGE B--ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

[Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Covered Persons in any one Accident or disaster shall not exceed the sum of <\$250,000 - \$1,000,000>. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed the above stated amount of indemnity payable for each Covered Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed the above stated amount.]

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.]

<SECTION 4>
[DESCRIPTION OF COVERAGES
COVERAGE C--REPATRIATION OF REMAINS BENEFIT

If Covered Person dies [from a Covered Sickness or Injury], [while [traveling / living] outside of his/her home country [[for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]]], the Insurer will pay the necessary expenses actually incurred[, up to the Maximum Limit shown in the Schedule of Benefits,] for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

No benefit is payable if the death occurs after the Termination Date of the Policy. [However, if the Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Termination Date.] The Insurer will not pay any claims under this provision unless the expense has been approved by the Plan Administrator before the body is prepared for transportation.

[This benefit is available only to Covered Persons who are living outside of their Home Country while engaged in educational activities.]

<SECTION 5>
[DESCRIPTION OF COVERAGES
COVERAGE D--MEDICAL EVACUATION BENEFIT

If an Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services], [while [traveling / living] outside of his/her home country [[for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]]], and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the [nearest appropriate / the Covered Person's choice of] medical facility. This medically-supervised evacuation will be to the [nearest / the Covered Person's chosen] medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services. Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Covered Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

The Insurer will pay Reasonable Charges for escort services if the Covered Person is a minor or if the Covered Person is disabled during a trip and an escort is recommended in writing by the attending Physician and approved by the Insurer.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

If following stabilization, when medically necessary and subject to the Administrator's prior approval, the Insurer will pay for a medically supervised return to the Covered Person's permanent residence or, if appropriate, to a health care facility nearer to their permanent residence or for one-way economy airfare to the Covered Person's point of origin, if necessary.

[For persons in the U.S., transportation home will be paid for only as a result of a Covered Injury or Sickness that prevents the Covered Person from continuing his/her scholastic program or covered trip. [For Covered Dependents not enrolled in an educational program, transportation home will be covered only as a result of a Covered Injury of Sickness which prevents the Covered Dependent from remaining in the U.S. with the Eligible Participant.]]

All evacuations must be approved and coordinated by Administrator designated physicians. Transportation must be by the most direct and economical route.

With respect to this provision only, the following is in lieu of the Policy's Extension of Benefits provision: No benefits are payable for Covered Expenses incurred after the date the Covered Person's insurance under the Policy terminates. [However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 31st day after the date of termination.]

The combined benefit for all necessary evacuation services is listed in Table 1 of the Schedule of Benefits.]

<SECTION 6>
[DESCRIPTION OF COVERAGES
COVERAGE E--BEDSIDE VISIT BENEFIT

If a Covered Person is Hospital Confined due to an Injury or Sickness for more than <7 – 14> days, is likely to be hospitalized for more than <7 – 14> days or is in critical condition,], [while [traveling / living] outside of his/her home country [[for an uninterrupted period of less than <90-364 ~~365~~> days / while traveling more than 100 miles from their place of residence [on an overnight trip]]], the Insurer will [pay / purchase] [up to the maximum benefit as listed in Table 1 of the Schedule of Benefits] for the cost of one economy round-trip air fare ticket to[, and the [meals] [and][hotel accommodations] in,] the place of the Hospital Confinement for one person designated by the Covered Person. Payment for [meals,] ground transportation and other incidentals are the responsibility of the family member or friend.

[With respect to any one trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip.] The determination of whether the Covered Member will be hospitalized for more than <7 – 14 days> or is in critical condition shall be made by the Administrator after consultation with the attending physician. No more than one (1) visit may be made during any Period of Coverage. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

[This benefit is available only to Covered Persons who are living outside of their Home Country while [covered under this Plan / engaged in educational activities].]]

<SECTION 7>
[LIMITATIONS

<A.> [Pre-Existing Condition Limitation

[The Insurer does [not] pay benefits for loss due to a Pre-Existing Condition.]

[The Insurer does [not] pay benefits for loss due to a Pre-Existing Condition during the first [60 days / 3 months / 6 months] of coverage.] [Pre-Existing Conditions will be covered after the Covered Person's coverage has been in force for [60 days / 3 months / 6 months; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.]

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[The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first [60 days / 3 months / 6 months] of coverage, except as follows: [The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the first [60 days / 3 months / 6 months] of coverage, subject to a maximum benefit of <\$100 - \$10,000> / . The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's pre-existing Sickness during the first [60 days / 3 months / 6 months] of coverage, subject to a maximum benefit of <\$100 - \$10,000>.] After the Covered Person has been covered under the Policy for [60 days / 3 months / 6 months], Pre-Existing Conditions will be covered the same as any other Injury or Sickness; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.]

/

[The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first [60 days / 3 months / 6 months] of coverage, except as follows:

1. The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first [30 days / 60 days / 3 months / 6 months] of coverage.
2. The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the next [30 days / one (1) month / 3 months / 6 months] so long as the Covered Person's coverage is continuous, subject to a maximum benefit of <\$100 - \$10,000>.
3. After the Covered Person has been covered under the Policy for [60 days / 3 months / 6 months], then Pre-Existing Conditions will be covered the same as any other Injury or Sickness; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.]]

[This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.]

<B.> [Limitation of Maternity Coverage.

The Policy does not pay benefits for maternity coverage unless conception occurred while the Covered Person was insured under the Policy .]]

<SECTION 8>
GENERAL POLICY EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

- <1.> [Expenses incurred in excess of Reasonable Expenses.]
- <2.> [Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health[, including routine care of a newborn infant][, unless otherwise noted].]
- <3.> [Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury[, unless otherwise noted].]
- <4.> [Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.]
- <5.> [Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.]
- <6.> [Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for in the Policy.]
- <7.> [Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.]
- <8.> [Elective termination of pregnancy.]
- <9.> [Expenses incurred as a result of pregnancy that is not covered.]
- <10.> [For diagnostic investigation or medical treatment for infertility, fertility, or birth control.]
- <11.> [Reproductive and infertility services.]
- <12.> [Expenses incurred for, or related to sex change surgery or to any treatment of gender identity disorders.]
- <13.> [Expenses incurred for Injury resulting from the Covered Person being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. [This exclusion does not apply [to the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]]
- <14.> [Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. [This exclusion does not apply to [the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]]
- <15.> [Organ or tissue transplant.]
- <16.> [Participating in an illegal occupation or committing or attempting to commit a felony.]
- <17.> [For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)]
- <18.> [While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.]
- <19.> [The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.]
- <20.> [Expenses incurred within the Covered Person's Home Country.]
- <21.> [Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, [TMJ dysfunction] or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia[, unless otherwise noted].]
- <22.> [Expenses incurred in connection with weak, strained or flat feet, corns or calluses.]

- <23.> [Diagnosis and treatment of acne [and sebaceous cyst].]
- <24.> [Expenses incurred as a result of [allergy testing], [allergy shots [or serums]], [Immunizations], [vaccinations], or [vitamins].]
- <25.> [Diagnosis and treatment of sleep disorders.]
- <26.> [Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.]
- <27.> [Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.]
- <28.> [Outpatient treatment for specified therapies including, but not limited to, Physiotherapy and acupuncture [which does not follow a covered Hospital Confinement or surgery].]
- <29.> [Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.]
- <30.> [Self-inflicted Injuries while sane or insane; suicide, or any attempt thereat [while sane or insane]. [This exclusion does not apply [to the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]]
- <31.> [Assistant surgeon's fees, except when required by the Hospital or as specifically provided.]
- <32.> [Expenses incurred for any services rendered by a family member or a Covered Person's immediate family or a person who lives in the Covered Person's home.]
- <33.> [[Unless specifically provided for elsewhere under the Policy][, the cost of treatment or services that are [provided normally without charge by Policyholder's Student Health Center][, covered or provided by the student health fee,] [rendered by an person employed by the Policyholder, including team Doctor and trainers] [or any other service performed at no cost.]
- <34.> [Loss due to [war, declared or undeclared][; service in the armed forces of any country or international authority][; riot][; civil commotion][; or acts of terrorism].]
- <35.> [Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.]
- <36.> [Injuries sustained as the result of an Accident involving a three-wheeled motor vehicle and/or off-road four wheeled motorized vehicles.]
- <37.> [Loss arising from
- [a. Participating in any intercollegiate/interscholastic or professional sport, contest or competition;]
 - [b. Participating in any intramural sport competition, contest or competition;]
 - [c. Participating in any club sport competition, contest or competition;
 - [d. Participating in any professional sport, contest or competition;]
 - [e. Traveling to or from such sport, contest or competition as a participant;]
 - [f. While participating in any practice or condition program for such sport, contest or competition;
 - [g. Racing or speed contests;]
 - [h. [Skin/scuba diving], [sky diving], [mountaineering (where ropes are customarily used)], [ultra light aircraft], [parasailing], [sail planning], [hang gliding], [bungee jumping], [travel in or on ATV's (all terrain or similar type vehicles)].]
- <38.> [Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.]
- <39.> [For Medical Benefits, Medical Evacuation, and Repatriation of Remains Benefits: Conditions caused by or contributed by (a) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from

such release of nuclear energy; (b) An Covered Person participating in the military service of any country; (c) An Covered Person participating in an insurrection, rebellion, or riot; (d) Services received for any condition caused by an Covered Person's commission of, or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.]

<40.> [Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.]

<41.> [[For Accidental Death and Dismemberment Benefits:] Conditions caused by or contributed by [(a) an act of war]; [b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy;] [(c) An Covered Person participating in the military service of any country;] [(d) An Covered Person participating in an insurrection, rebellion, or riot;] [(e) Services received for any condition caused by an Covered Person's commission of, or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.]

<43.> Services or supplies that the Insurer considers to be Experimental or Investigative.

<44.> [Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.]

<45.> [Treatment of Mental, Emotional or Functional Nervous Disorders (including nicotine use) or psychological testing except as specifically stated in this Plan. However, medical conditions that are caused by behavior of the Covered Person and that may be associated with these mental conditions are not subject to these limitations.]

<46.> [Hearing aids.]

<47.> [Routine hearing tests except as provided under Preventive and Primary Care.]

<48.> [Outpatient speech therapy.]

<49.> [Outpatient speech therapy.]

<50.> [Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage.]

<SECTION 9> DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Age means the Covered Person's attained age.

[Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.]

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Certificate of Coverage is the document issued to each Eligible Participant outlining the benefits under the Plan.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Reasonable Expenses for Medically Necessary treatment. The percentage the Insurer pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

[Copayment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.]

[Country of Assignment means the country for which the Eligible Participant has a valid visa, if required, and in which he/she is undertaking an educational activity.]

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

1. Administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. Are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section <3>.

Covered Person means an Eligible Participant [and any Eligible Dependents] as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person [on a per Injury or per Sickness][Period of Coverage] basis before certain benefits are payable under the Policy. The Deductible Amounts are stated in the Schedule of Benefits.

[Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.]

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

[Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse [partner] and/or his/her unmarried children under age <18 – 27> who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who

1. [With a similar visa or passport,] accompanies the Eligible Participant while that person is engaged in [international] educational activities[; and]

<2.> [Is temporarily located outside the Eligible Participant's Home Country as a non-resident alien]; and

<3.> [Has not obtained permanent residency status.]]

As used above:

<1.> [The term “partner means an Eligible Participant’s spouse or domestic partner.]

<2.> [The term “domestic partner” means a person of the same sex who:

<a.>[Is not married or legally separated;]

<b.>[Has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;]

<c.>[Is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;]

<d.>[Occupies the same residence as the Eligible Participant;]

<e.>[Has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature;] [and]

<f.>[Has entered into a domestic partnership arrangement with the named Insured.]]

<3.> [The term “domestic partnership arrangement means the Eligible Participant and another person of the same sex has any three of the following in common:

<a.>[Joint lease, mortgage or deed;]

<b.>[Joint ownership of a vehicle;]

<c.>[Joint ownership of a checking account or credit account;]

<d.>[Designation of the domestic partner as a beneficiary for the Eligible Participant’s life insurance or retirement benefits;]

<e.>[Designation of the domestic partner as a beneficiary of the employee’s will;]

<f.>[Designation of the domestic partner as holding power of attorney for health care;] [or]

<g.>[Shared household expenses.]]

Eligible Participant means a person who:

1. Is engaged in international educational activities[; and]

<2.> [Is temporarily located outside his/her Home Country as a non-resident alien;] [and]

<3.> [Has not obtained permanent residency status.]

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:

1. Permanently placing the Covered Person’s health in jeopardy, or

2. Causing other serious medical consequences; or

3. Causing serious impairment to bodily functions; or

4. Causing serious and permanent dysfunction of any bodily organ or part.

Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time shall not be included in this definition of a medical emergency, unless symptoms suddenly become so severe that immediate medical aid is required.

Experimental or Investigative means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the final determination as to what is Experimental or Investigative.

Group means a preparatory or high school; an institution of higher learning offering a course of general studies leading to a bachelor's degree, master's degree or doctorate; a part of a university offering a specialized group of courses; or an institution offering instruction in a professional, vocational, or technical field.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster received from the Participating Organization or Institution, as applicable. [However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.]

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

[HTH means Highway to Health (d/b/a HTH Worldwide). This is the entity that provides the Covered Person with access to online databases of travel, health, and security information and online information about physicians and other medical providers outside the U.S.]

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the Policy. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Medically Necessary services or supplies are those that the Insurer determines to be **all** of the following:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
2. Provided for the diagnosis or direct care and treatment of the medical condition.
3. Within standards of good medical practice within the organized community.
4. Not primarily for the patient's, the Physician's, or another provider's convenience.
5. The most appropriate supply or level of service that can safely be provided. For Hospital stays, this means acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy.

[Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.]

[Non-hospital Residential Facility means a facility certified by the District or by any state or territory of the United States as a qualified nonhospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. The term “non hospital residential facility” includes any facility operated by the District, any state or territory, or the United States, to provide these services in a residential setting.]

[Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile “no fault” and “traditional fault” type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or 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 when, by law, its benefits are excess of those of any private program or other non-governmental program.]

[Out-of-Pocket Limit means the amount of Reasonable Expenses which the Covered Person must pay after which the Insurer pays 100% of the reasonable Expenses, subject to the limits and provisions of the Policy.]

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician’s office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

[Outpatient treatment facility means a clinic, counseling center, or other similar location that is certified by the District or by any state or territory as a qualified provider of outpatient services for the treatment of drug abuse, alcohol abuse, or mental illness. The term “outpatient treatment facility” includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.]

[Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.]

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Physiotherapy means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

Period of Coverage means the period beginning on the Covered Person’s effective date. It ends on the earlier of:

1. The date the Covered Person’s insurance under the Policy ends; or
2. The last day of the current School Year as defined by the Participating Organization or Institution; or
3. The date the Covered Person returns to his or her Home Country; or
4. 364 days from the Covered Person’s effective date at 11:59 PM.

School Year means the period of time commencing on the [first day of the fall semester and ending on the last day of the spring semester as defined] [date determined] by the Organization or Institution.

[Preferred Provider means a Hospital, Physician, or other health care provider who has agreed to participate in the PPO and who has agreed to accept negotiated rates for charges for Covered Medical Expenses. Preferred Providers have agreed to accept the negotiated rate as payment in full.]

[Preferred Provider Organization (PPO) means the network(s) of Preferred Providers stated on the Covered Person’s identification card.]

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received [up to 60 days / 3 months / 6 months / one (1) year / two years] prior to the Covered Person’s effective date of coverage.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. For a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. For a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

[Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students [for a minimum of <10 – 40>] hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider [and is approved as a Recognized Student Health Center by the Administrator].]

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters “R.N.” or “R. P.N.” after his/her name.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Policy.

[Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person’s complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person’s inability to engage in the normal activities of a person of like age and sex while:
 - a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
 - b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.]

[Written Request means a request on any form provided by the Administrator for particular information.]

[11:59:59 p.m. means 11:59:59 p.m. at the Covered Person’s location.]

[12:00:01 a.m. means 12:00:01 Eastern Prevailing Time in Washington, DC.]

**<SECTION 10>
[EXTENSION OF BENEFITS**

[No benefits are payable for medical treatment benefits after the Covered Person’s insurance terminates. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date:

1. The Confinement ends; or
2. 31 days after the date the insurance terminates; or
3. The end of the current Period of Coverage.]

/

[If the Insurer terminates the Policy, coverage will be extended for a Covered Person who:

1. Is Totally Disabled on the date coverage ends[; or]

<2.> [Is pregnant on the date coverage ends if the pregnancy manifested itself while insurance was in force under the Policy].

Coverage under this provision is provided only for Covered Medical Expenses with respect to:

1. A Totally Disabled Covered Person, for the condition causing the Total Disability[; and]

<2.> [A pregnant Covered Person, for that pregnancy, childbirth or miscarriage.]

Coverage so extended will end on the first of the following to occur:

1. The 90th day following termination of the Policy; or

2. The date the Total Disability ends[; or]

<3.> [The end of the pregnancy; or]

<4.> [The end of the current Period of Coverage].]

Except as stated above, coverage is not provided for any expense incurred after the date the Policy terminates.

This coverage extension will not apply to termination initiated by any Covered Person, Participating Organization or Institution or the Policyholder.]

**<SECTION 11>
[EXTENSION OF COVERAGE**

[Coverage as shown in the Schedule of Benefits will be extended for a Covered Person, provided the appropriate premium has been paid, for a period of <30 - 90 days> after the conclusion of the assignment in the Country of Assignment, but not beyond the end of the current Period of Coverage. Treatment provided within the Covered Person's Home Country will be considered as Covered Medical Expenses while coverage is extended.]

/

[Expenses for conditions first diagnosed or treated while in the Country of Assignment incurred in a Covered Person's Home Country within <30 – 120> days after termination of coverage will be considered Covered Medical Expenses [up to <\$1,000 - \$25,000>.]

/

[Expenses for conditions contracted as a direct result of the assignment in the Country of Assignment incurred in a Covered Person's Home Country within <30 – 120> days after termination of coverage will be considered Covered Medical Expenses [up to <\$1,000 - \$25,000>.]]

**<SECTION 12>
[EXCESS COVERAGE**

The Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies.

/

COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any [policy year / calendar year.] This helps to hold down the costs of health coverage.

COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

The term “plan” applies separately to each policy, contract agreement or other arrangements for benefits or services. The term “plan” also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid. This provision may not be applied to claims less than <\$50 – \$250>, but if additional liability is incurred to raise the small claim above <\$50 – \$250>], the entire liability may be included in the coordination of benefits computations.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If this primary plan’s payment is less than the charge for the allowable expense, then the second-paying (secondary) plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
 - a. First, benefits of a plan covering persons as an employee, member, or subscriber.
 - b. Second, benefits of a plan of an active worker covering persons as a dependent.
 - c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
 - a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
 - b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
 - c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
 - d. When the parents are separated or divorced and the parent with custody has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
 - f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured’s dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured’s dependent. This rule will not apply if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits.
5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:

- a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. When rules 2 through 5 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by the Insurer, the Insurer has the right to pay the other plan any amount the Insurer deems necessary to satisfy the Insurer's obligation under these COB rules.

Right of Recovery. If the amount of the Insurer's benefit payment is more than the amount needed to satisfy the Insurer's obligation under these COB rules, the Insurer has the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. The Insurer has the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as the Insurer deems necessary; and
2. Any person claiming benefits under this plan must give the Insurer any information necessary to carry out this provision.]

<SECTION 13> ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1—Eligible Classes. [He/she must not be insured under the Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.]

Enrollment for Coverage: An Eligible Participant must enroll for coverage by completing an enrollment form and paying any required premium prior to the date he or she arrives in the Country of Assignment. [If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; [or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.]

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

- <1.> The effective date shown on the Insurance Identification Card, if any;
- <2.> The date the requirements in Section 1—Eligible Classes are met; or
- <3.> The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide [except whenever the Covered Person is in his/her Home Country]. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

[For Transfers Only: If a Covered Person transfers from a Group which has coverage under a policy issued on the same form as this plan of insurance to another Group which also has coverage under the same policy form, or transfers from one plan to another under the same policy, he / she will be covered under the newer plan for medical conditions which first arise on or after the transfer date. A Pre-Existing Condition will not be covered under the newer plan until the benefit period expires for such condition under the prior plan (the plan under which the Covered Person was insured prior to the date of transfer). At that time, the Pre-Existing Condition will be covered under the newer plan. Benefit payments for Pre-Existing Conditions shall be the lesser of:

1. The unused portion of the maximum benefit applicable to the covered medical condition under the prior plan; or
2. The maximum benefit applicable to the covered medical condition under this plan.

Both 1 and 2 above are subject to the benefit periods, Deductibles, and Coinsurance as defined in the respective policies.]

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
- <2.> [The Participating Organization's or Institution's Termination Date;]
- <3.> The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
- <4.> The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
- <5.> The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
- <6.> The premium due date for which the required premium has not been paid, subject to the Grace Period provision.
- <7.> The end of any Period of Coverage.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage [or if the enrollment form contained inaccurate or misleading information].

Coverage will end at 11:59:59 p.m. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

At the end of any Period of Coverage an Eligible Participant may re-enroll by completing an enrollment form and paying any required premium.

[When an Eligible Dependent's Coverage Starts: An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, entry into or departure from the Country of Assignment. An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

- <1.> The effective date of the Eligible Participant's insurance;
- <2.> The effective date shown on the insurance identification card, if any;
- <3.> The date the eligibility requirements in this section are met; or
- <4.> The date the completed enrollment form, if any, and premium are received by the Insurer. Thereafter, the insurance is effective 24 hours a day, worldwide [except whenever the Covered Person is in his/her Home Country.] In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.]

[When an Eligible Dependent's Coverage Ends. An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates; or
- <2.> [The Participating Organization's or Institution's Termination Date;]
- <3.> The date the Eligible Participant is no longer covered under the Policy;
- <4.> 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country;
- <5.> The date the Covered Person requests cancellation of coverage (the request must be in writing);
- <6.> The premium due date for which the required premium has not been paid, or
- <7.> The date on which the dependent ceases to meet the eligibility requirements.
- <8.> The end of any Period of Coverage.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.]

At the end of any Period of Coverage an Eligible Participant may re-enroll his or her Eligible Dependents by completing an enrollment form and paying any required premium.

<SECTION 14>
[COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits. ["Expenses for Routine nursery care" of a newborn infant of a covered Pregnancy are covered up to the limits, if any, shown in the Schedule of Benefits.]

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of placement for adoption, provided the Eligible Participant's coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement.

[Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.]

[Expenses for routine nursery care means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.]

In order to continue the coverage of a newborn child beyond the 31st day following his/her date of birth or of an adopted child beyond the 31st day following his/her placement:

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 31 days from the date of birth or placement.]

<SECTION 15>
[PREMIUM FOR INDIVIDUAL ENROLLMENT]

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid monthly, in three month increments, in six month increments or for a Period of Coverage, as arranged with the Administrator. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Covered Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Renewing Coverage: The benefits provided by this Certificate terminate at the end of the current Period of Coverage. At the end of any Period of Coverage an Eligible Participant, if [an International Student Eligible Participant] [or] [a Study Abroad Student Eligible Participant], may re-enroll by completing an enrollment form and paying the required premium. Premiums will be based upon the attained age of the Covered Person at the time of renewal. Any Covered Person whose coverage under the Policy lapses may re-enroll and shall be subject to all Policy exclusions as of any subsequent effective date.

Grace Period: There is a 31 day grace period after the premium due date in which to pay the required premium. The Policy and affected coverage will stay in force during the grace period. The grace period does not apply to payment of the first premium or the last premium when the Covered Person requests to terminate coverage. The Covered Person is liable for all premium unpaid, including any part or entire premium due through the grace period.

Cancellation Requirements: Cancellation will only be allowed if one of the following three requirements are met:

1. Proof of ineligibility is provided; or
2. Claims have not been submitted; or
3. Cancellation occurs within the first 60 days from the effective date or from the effective date of the most recent ~~renewal date~~ Period of Coverage; and
4. The Covered member requests cancellation in writing.

A full refund will be given. A \$50 administration fee deducted from the premium will be charged. If cancellation is after 60 days, 100% of the premium is earned and a refund will not be given.]

<SECTION 16>
CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Policy which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the

Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to \$1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

[All benefits payable under the Policy shall be payable to the Insured or to his/her designated beneficiary or beneficiaries, or to his/her estate. If the Insured is a minor, benefits may be payable to his/her parents, guardian, or other person actually supporting him/her, or to a person or persons upon whom such minor is chiefly dependent upon for support and maintenance.]

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

<SECTION 17> GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Participating Organization or Institution, copies of which are attached to and made a part of the Policy. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Policy has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Policy unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after <1 - 2> year[s] from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Policy.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers' compensation. The Policy does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Policy in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

Grievance Procedures: If the Covered Person's claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

The Covered Person has the right to appeal any denial of a claim for benefits by submitting a written request for reconsideration with the Insurer. Requests for reconsideration must be filed within 60 days after receipt of the written notification of denial. When the Insurer receives the Covered Person's written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Covered Person's satisfaction, he/she may request a second review of the claim by sending the Insurer a written request for a second reconsideration. This written request must be filed within 60 days of the Eligible Participant's receipt of the Insurer's written notification of the result of the first review. If the issue involves a dispute over the coverage of medical services, or the extent of that coverage, the second review will be completed by physician consultants who did not take part in the initial reconsideration. The Covered Person will be informed, in writing, of the Insurer's final decision.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Eligible Participant or the Group because the Eligible Participant, the Group, or any person acting on the Eligible Participant's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

The Insurer will meet any Notice requirements by mailing the Notice to the Group at the billing address listed on our records. The Group will meet any Notice requirements by mailing the Notice to:

HM LIFE INSURANCE COMPANY
120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433

Dispute Resolution

All complaints or disputes relating to coverage under this Plan must be resolved in accordance with the Insurer's grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by the Insurer that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Covered Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer propose to resolve the grievance.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Insured Participant and his/her Insured Dependents or the Group because the Insured Participant's, the Group's, or any person's action on the Covered Person's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

SERFF Tracking Number: HMRK-126907796 State: Arkansas
 Filing Company: HM Life Insurance Company State Tracking Number: 47342
 Company Tracking Number: HM207-SI GP 1010
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Student Accident & Sickness
 Project Name/Number: Student Short Term Filing/HM207-SI GP (10/10)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	11/23/2010
Comments:		
Attachment: Readability Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	11/23/2010
Comments: previously approved application 04/30/2007- HMRK-125143904		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	11/23/2010
Comments: not PPACA related; short term coverage.		

	Item Status:	Status Date:
Satisfied - Item: Submission Letter	Approved-Closed	11/23/2010
Comments:		
Attachment: AR Submission Letter 2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Red-Lined Policy	Approved-Closed	11/23/2010
Comments:		
Attachment:		

SERFF Tracking Number: HMRK-126907796 State: Arkansas
Filing Company: HM Life Insurance Company State Tracking Number: 47342
Company Tracking Number: HM207-SI GP 1010
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student Accident & Sickness
Project Name/Number: Student Short Term Filing/HM207-SI GP (10/10)
Student Policy HM207-SI GP _10-10_ marked.pdf

	Item Status:	Status
Satisfied - Item: Red-Lined Certificate	Approved-Closed	Date: 11/23/2010
Comments:		
Attachment:		
Short Term Student Certificate HM1207-SI GC _10-10_ marked.pdf		

STATE OF ARKANSAS
READABILITY CERTIFICATION

This is to certify that the following forms comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch Reading Ease Score of:

FORM NO.
HM207-SI GP (10/10) and related forms

FLESCH SCORE
51



Signed by Company Officer

November 4, 2010
Date

Domenic Palmieri
Name
Senior Vice President – Finance
Title



A HIGHMARK COMPANY

HM Life Insurance Company

HM Life Insurance Company of New York

HM Casualty Insurance Company

RBS Re

HM Benefits Administrators

November 18, 2010

Arkansas Insurance Department
Life & health Division
1200 W. Third Street
Little Rock, AR 72201-1904

RE: HM Life Insurance Company, NAIC #93440
Student Accident and Sickness Insurance Form Filing
Form HM207-SI GP (10/10) – Student Accident and Sickness Policy
Form HM207-SI GC (10/10) – Student Accident and Sickness Certificate

Dear Sir or Madam:

Enclosed for filing with your department are the above-captioned forms. When approved, Policy Form Series HM207-SI GP (10/10), et al. will replace existing business issued on the following forms, at the next renewal following the date of approval:

Table with 3 columns: Form, Approved, Filing Number. Rows include Form HM207-SI GP and Form HM207-SI GC with their respective approval dates and filing numbers.

The attached forms will also be used for new business issued after the date of approval. The following forms will continue to be used with HM207-SI GP (10/10), et al.

Table with 3 columns: Form, Approved, Filing Number. Rows include HM207-SI (AR) and HM207-SI-E(AR)(07/09) with their respective approval dates and filing numbers.

A "red-lined" copy and clean copy of the referenced forms is enclosed. In the "red-lined" copy:

- Provisions and text that have been deleted are struck through;
• New, changed or additional text is underlined in red.

The clean copy contains clear text. Optional limits, wording or provisions are bracketed –

- [] Bold Brackets indicate that this section within brackets may be included or excluded.
[] Brackets in regular print indicate that this sentence, clause, or word may be included or excluded.
{/ } Bold Brackets with a / indicate that in the construction of the certificate that the writer may choose among the options presented within the Bold Brackets. The / indicates that one choice has ended and a new one is about to begin.
{/ } Brackets of this type in regular print indicate choices within sections of the {/ }.

Mailing Address
PO Box 535061
Pittsburgh, PA 15253-5061

Overnight Deliveries
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

www.hminsurancegroup.com

Telephone
412-544-1000
800-328-5433

Coverage is underwritten by HM Life Insurance Company or HM Casualty Insurance Company, Pittsburgh, PA in all states except New York. In New York, coverage is underwritten by HM Life Insurance Company of New York, New York, NY. HM Life Insurance Company, HM Benefits Administrators and RBS Re provide certain administrative and customer support services. The coverage or service requested may not be available in all states.



A HIGHMARK COMPANY

HM Life Insurance
Company

HM Life Insurance
Company of New York

HM Casualty
Insurance Company

RBS Re

HM Benefits
Administrators

<# - #> Brackets of this type provide a range of numbers within which the writer of the policy must choose a number for the particular certificate.

<#> Brackets with a single number, letter, or "Section 3" simply indicate that the next number, letter, or Section # in sequence should occur. They will vary according to the variables chosen.

In order to accommodate our policyholders' specific needs, we request that these forms be approved as variable on a general-use basis. You have our assurance we will not add to or revise any language, but only remove language in the manner described in the memorandum. Any variability will be administered within your state's requirements. To the best of my knowledge, the forms comply with all of your applicable statutes.

The Policy will be issued directly to educational institutions or associations sponsoring educational activities. It is primarily designed to provide short term coverage to individuals engaged in educational activities outside of the participant's home country. All individuals enrolled in or associated with a participating education institution or an association sponsoring educational activities may participate in the program. To obtain coverage an individual must:

- Be enrolled in or associated with an educational institution or an association sponsoring educational activities; and
- Intend to pursue an educational activity outside his or her home country; and
- Enroll prior to leaving for his or her "country of assignment".

For foreign nationals the "country of assignment" is the United States - for citizens or residents of the United States the "country of assignment" is any foreign country.

Coverage ends at the earlier of:

- The last day of the educational institutions school year; or
- The date the individual returns to his or her Home Country; or
- 364 days from the individual effective date of coverage.

Should you have any questions or concerns, please do not hesitate to contact me. I may be reached directly at the left-side address, as well as via telephone at 412-544-0923, or via e-mail to jennifer.bayich@hminsurancegroup.com.

Thank you for your time and attention to this matter.

Sincerely,

Jennifer L. Bayich, Esq.

Compliance Analyst III

Mailing Address

PO Box 535061
Pittsburgh, PA 15253-5061

Overnight Deliveries

Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

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Telephone

412-544-1000
800-328-5433

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

1-800-328-5433

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

POLICYHOLDER: [Specimen] (the "Participating Organization or Institution")

POLICY EFFECTIVE DATE: <###>

POLICY NUMBER: <###> ("the Policy")

STATE OF DELIVERY: [State]

ADMINISTRATOR: [ABC Administrator]

This Policy is a legal contract between the Policyholder and **HM Life Insurance Company** (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGREEMENT

This Policy, the Certificates issued under the policy, the application of the Policyholder ~~and the application of the Participating Organization or Institution~~ form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by a Covered Person, by the Insurer's Agent, or by any other person are not part of this Policy. Only the Insurer's President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Covered Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

POLICY TERM

Policy Effective Date: <###>

Policy Termination Date: The Policy will continue in force while the required premiums are paid until the Policy is terminated by either the Policyholder or by the Insurer. At least <31 – 90> days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Participating Organization's or Institution's coverage under the Policy may be canceled at any time after <31 – 90> days written notice mailed or delivered by the Insurer to the Participating Organization or Institution or by the Participating Organization or Institution to the Insurer.

If the Insurer cancels the coverage under Policy, the Insurer will mail or deliver the written notice to the Participating Organization or Institution at the last address stated in the Insurer's records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the <32nd – 91st day after the Insurer mails or delivers the written notice.

If the Participating Organization or Institution cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

If the Participating Organization or Institution or the Insurer cancels the coverage under the Policy, the Covered Person's coverage will continue through the end of his/her Period of Coverage, provided the Insurer has received the applicable premium.

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Covered Person's Period of Coverage. No benefit is payable for charges incurred after the effective date of the cancellation of coverage under the Policy, except as provided in the Policy's benefit provisions.

[Cancellation of Covered Person's Coverage: A Covered Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.]

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly or semi-annually, ~~annually~~, for the entire Policy Term, or for a specified time period ~~term~~ less than 364 days ~~one year~~. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Covered Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect. "Policy Terms" are successive 12 month periods beginning on the Policy Effective Date.

Premium Due Dates: The Covered Person's first premium is due and payable on the Covered Person's Period of Coverage Effective Date.

Change in Premium: ~~{The Insurer may change the premiums due on or after the first Policy Anniversary Date, [but not more often than once in any 12 month period]. The Insurer shall give~~ by giving written notice of such change at least <31 – 90> days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended.

~~The Insurer has the right to change the rate at which Premium will be calculated for any time period or Period of Coverage under the Policy. If the Insurer changes rates~~ during a Policy Term, the change will apply only to a Periods of Coverage starting on or after the effective date of the change. The Insurer will give the Participating Organization or Institution at least 31 days advance written notice of any change.} [The Insurer will not change rates during the initial PolicyTerm.]

[Renewing Coverage: The Participating Organization or Institution may renew the coverage provided by the Policy for another Policy Term by completing an Coverage for all Covered Persons shall be continuous if the acceptable renewal form. Renewal is subject to the Insurer's written approval and receipt of premium are received by the Insurer prior to the end of the current Policy Term expiration of coverage. There is a 31 day grace period in which to pay the premium due. ~~[Premiums will be based upon the attained age of the Covered Person at the time of renewal.] [Any Covered Person whose coverage under the Policy lapses may not re-enroll until the next enrollment period and shall be subject to all Policy exclusions as of any subsequent effective date.]~~ The Insurer further reserves the right to re-determine the premium rate at the end of any Policy Term. [Renewals may be subject to a minimum premium payment.]]

[Group, Full Cancellation: If the Administrator accepts the request for cancellation and the cancellation occurs within 180 days of the effective date, a full refund will be given if there are no claims filed or paid. Cancellation is not effective until the beginning of the month after which claims have been filed. If the cancellation occurs 180 days or more after the effective date, a refund will not be given. Exceptions are not granted if notice is received after 180 days or more. Calculation of 180 days via web or fax is the date submitted or faxed. Calculation of 180 days via paper is the postmark date.]

[Group, Partial Cancellation: All premium is earned within 180 days from date of enrollment of a Covered Person if there are no claims filed or paid. If there are claims, all premium is earned. If there are no claims, the refund is based upon the following:

Length of Time from Enrollment Date	Premium Earned	Percent Refund
0-60 days	0%	100%
61-120 days	50%	50%
121-180	80%	20%
181 days or more	100%	0%

[Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator.]

[Cancellation Requirements: Cancellation will only be allowed if one of the following three requirements are met:

1. proof of ineligibility is provided;
2. claims have not been submitted; or
3. cancellation occurs within the first 60 days from the effective date or most recent renewal date.

A full refund will be given. [A \$50 administration fee deducted from the premium will be charged. If cancellation is after 60 days, 100% of the premium is earned and a refund will not be given.]]

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of **HM Life Insurance Company**.

A handwritten signature in cursive script that reads "Mike Sullivan". The signature is written in dark ink and is positioned above the title "President".

President

**BLANKET INSURANCE POLICY
PROVIDING STUDENT ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable**

HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

CERTIFICATE OF COVERAGE

BLANKET **SHORT TERM** STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. [###] (“the Policy”)

Participating Organization or Institution:	[DEF Organization /GHI Institution]
Participating Organization’s or Institution’s Effective Date:	<JANUARY 1, 20XX>
Eligible Participant:	See Identification Card Issued to Participant
[Eligible Dependents:	See Identification Card Issued to Participant]
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant [and an Eligible Dependent] as a “Covered Person,” and to **HM Life Insurance Company** as “Insurer.” The Policy will be administered on behalf of the Insurer by the Administrator:” Worldwide Insurance Services, Inc., aka “HTH Worldwide”.

The benefits provided by this Certificate terminate at the end of the current Period of Coverage.

~~This Certificate replaces all certificates previously issued to the Eligible Participant as evidence of coverage under the Policy.~~

At the beginning of the next Period of Coverage an Eligible Participant may re-apply for his / her coverage. Any re-application is subject to the Insurer’s approval and payment of any applicable premium by the Eligible Participant to the Insurer. Premiums will be based upon the attained age of the Covered Person at the beginning of the Period of Coverage.



President

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**SECTION 1
SCHEDULE OF BENEFITS**

ELIGIBLE CLASSES

[The Classes eligible for coverages available under the Policy are shown below. [The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.]]

- [___] Class I: Regular, full-time Eligible International Participants of the [educational] organization or institution enrolled in at least <4 – 16> hours [and their Eligible Dependents].]
- [___] Class II: Part-time Eligible International Participants of the [educational] organization or institution [and their Eligible Dependents].]
- [___] Class III: [Mandatory] [Voluntary] - Eligible International Participants.]
- [___] Class IV: Voluntary - Eligible International Dependents - Spouse.]
- [___] Class V: Voluntary - Eligible International Dependents - Child.]
- [___] Class VI: Study Abroad Student Eligible Participants enrolled in the educational institution’s sponsored or approved study abroad program [and their Eligible Dependents].]
- [___] Class VII Study Abroad Staff Eligible Participants providing direct support to the educational institution’s sponsored or approved study abroad program at its Country of Assignment location [and their Eligible Dependents].]

All benefits and limits are stated per Covered Person

SCHEDULE OF BENEFITS

TABLE 1

	Limits Eligible Participant	Limits [Spouse / Dependent]	Limits Child
[COVERAGE A--MEDICAL EXPENSES			
[Lifetime Maximum Benefit	<\$1,000 – \$1,000,000>	<\$1,000 – \$1,000,000>	<\$1,000 – \$1,000,000>]
[Policy Year- <u>Period of Coverage</u> Maximum Benefits	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>]
[Maximum Benefit per Injury or Sicknesses	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>	<\$1,000 - \$1,000,000>]
[Basic Medical Expense Benefit [per Injury or Sickness / <u>per Lifetime</u> / <u>per Policy Year- Period of Coverage</u>]	Up to <\$0 - \$1,000,000> Maximum: <50% - 100%> of Reasonable Expenses after Deductible.	Up to <\$0 – 1,000,000> Maximum: <50% - 100%> of Reasonable Expenses after Deductible.	[Up to <\$0 - \$1,000,000> Maximum: <50% - 100%> of Reasonable Expenses after Deductible.]
[Supplemental Major Medical Expense Benefit (SMM) [per Injury or Sickness / <u>per Lifetime</u> / <u>per Policy Year- Period of Coverage</u>]	After Basic Medical Expense Benefit Maximum has been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum	After Basic Medical Expense Benefit Maximum has been paid, , <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum	After Basic Medical Expense Benefit Maximum has been paid, , <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum]

TABLE 1 (Continued)

<p>[Catastrophic Major Medical Expense Benefit (CMM) [per Injury or Sickness /per Lifetime / per Policy Year <u>Period of Coverage</u>]</p>	<p>After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum</p>	<p>After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum</p>	<p>[After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, <50% - 100%> of Reasonable Expenses up to an additional <\$0 - \$1,000,000> Maximum]</p>
<p>[Pregnancy coverage</p>	<p>Reasonable Expenses [up to <\$100 - \$25,000>] Maximum per Policy Year <u>Period of Coverage</u></p>	<p>Reasonable Expenses [up to <\$100 - \$25,000>] Maximum per Policy Year <u>Period of Coverage</u></p>	<p>Reasonable Expenses [up to <\$100 - \$25,000>] Maximum per Policy Year <u>Period of Coverage</u>]</p>
<p>[Deductible. [(Deductible is reduced to <\$0 - \$50> if treatment is received at Recognized Student Health Center or if initial treatment is received at Recognized Student Health Center.)]</p>	<p>[<\$0 - \$5,000> per Injury or Sickness [and limited to <\$100 - \$5,000> per Policy Year <u>Period of Coverage</u>] / <\$0 - \$5,000> per Policy Year <u>Period of Coverage</u> per Covered Person [and limited to <\$100 - \$5,000> per Family per Policy Year <u>Period of Coverage</u>]]</p>	<p>[<\$0 - \$5,000> per Injury or Sickness [and limited to <\$100 - \$5,000> per Policy Year <u>Period of Coverage</u>] / <\$0 - \$5,000> per Policy Year <u>Period of Coverage</u> per Covered Person [and limited to <\$100 - \$5,000> per Family per Policy Year <u>Period of Coverage</u>]]</p>	<p>[<\$0 - \$5,000> per Injury or Sickness [and limited to <\$100 - \$5,000> per Policy Year <u>Period of Coverage</u>] / <\$0 - \$5,000> per Policy Year <u>Period of Coverage</u> per Covered Person [and limited to <\$100 - \$5,000> per Family per Policy Year <u>Period of Coverage</u>]]</p>
<p>[[Policy Year <u>Period of Coverage</u> / Maximum] Out-of-Pocket Limit [for any one Injury or Sickness]</p>	<p>After the Covered Person reaches a <\$100 – \$10,000> Out-of-Pocket Limit [per Injury or Sickness] [per Policy Year <u>Period of Coverage</u>], the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit.</p>	<p>After the Covered Person reaches a <\$100 – \$10,000> Out-of-Pocket Limit [per Injury or Sickness] [per Policy Year <u>Period of Coverage</u>], the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit</p>	<p>After the Covered Person reaches a <\$100 – \$10,000> Out-of-Pocket Limit [per Injury or Sickness] [per Policy Year <u>Period of Coverage</u>], the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit]</p>
<p>Out-of-Pocket Limit means the amount of Reasonable Expenses for which the Covered Person is responsible after which the Insurer pays 100% of the Reasonable Expenses, subject to the limits and provisions of the Policy.]</p>			
<p>[COVERAGE B-- ACCIDENTAL, DEATH AND DISMEMBERMENT</p>	<p style="text-align: center;">Limits Eligible Participant</p> <p>Maximum Benefit Principal Sum up to <\$500 - \$100,000></p>	<p style="text-align: center;">Limits [Spouse / Dependent]</p> <p>Maximum Benefit Principal Sum up to <\$500 - \$100,000></p>	<p style="text-align: center;">Limits Child</p> <p>Maximum Benefit Principal Sum up to <\$500 - \$100,000>]</p>
<p>[COVERAGE C REPATRIATION OF REMAINS</p>	<p>Maximum Benefit up to <\$1,000 - \$100,000></p>	<p>Maximum Benefit up to <\$1,000 - \$100,000></p>	<p>Maximum Benefit up to <\$1,000 - \$100,000>]</p>
<p>[COVERAGE D MEDICAL EVACUATION</p>	<p>[Maximum Lifetime Benefit for all Evacuations up to <\$10,000 - \$1,000,000>/ Reasonable Cost of the Evacuation as determined by the Insurer]</p>	<p>[Maximum Lifetime Benefit for all Evacuations up to <\$10,000 - \$1,000,000>/ Reasonable Cost of the Evacuation as determined by the Insurer]</p>	<p>[Maximum Lifetime Benefit for all Evacuations up to <\$10,000 - \$1,000,000>/ Reasonable Cost of the Evacuation as determined by the Insurer]]</p>

TABLE 1 (Continued)

**[COVERAGE E
Bedside Visit**

Up to a maximum benefit of <\$500 - \$5,000> for the [cost / purchase] of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person

Up to a maximum benefit of <\$500 - \$5,000> for the [cost / purchase] of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person

Up to a maximum benefit of <\$500 - \$5,000> for the [cost / purchase] of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person]

SCHEDULE OF BENEFITS
TABLE 2

COVERAGE A--MEDICAL EXPENSES

[Indemnity Plan Limits

[PPO Plan In PPO Limits+

[PPO Plan Outside PPO Limits

[Physician Office Visits[*]]

[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible[/ and / or / and/or] <\$5 - \$200> Copayment per visit.].]]

[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] / Deductible waived.]

[[[For Basic,] [After Deductible], <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] / Deductible waived.]

[Inpatient Hospital Services [not including Emergency Hospital Services]

[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.].]]

[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] / Deductible waived.]

[[[For Basic,] [After Deductible], <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] / Deductible waived.]

[Maximum payment for all Hospital Services delivered in association with semi-private accommodations up to <\$200 - \$2,000> per day.]

[Maximum payment for all Hospital Services delivered in association with care in an Intensive Care Facility up to <\$200 - \$3,000> per day.]

[Hospital and Physician Outpatient Services]

[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.].]]

[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] / Deductible waived.]

[[[For Basic,] [After Deductible], <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [/ and / or / and/or] <\$5 - \$200> Copayment per visit.].] / Deductible waived.]

[Maximum payment for all Hospital and Physician Outpatient Services delivered in association with [an Injury or a Sickness / each diagnosis] is limited to <\$200 - \$10,000> per [Injury or Sickness / each diagnosis].]

**[Hospital and Physician
Outpatient Services]**

[Maximum payment for all Hospital and Physician Outpatient Services delivered in association with [an Injury or a Sickness / each diagnosis] is limited to <\$200 - \$10,000> per [Injury or Sickness / each diagnosis].]

[[[For Basic,] [after Deductible] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit].] [For CMM, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit].]]

[[[For Basic,] [after Deductible,] <50% - 100%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit.]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]

[[[For Basic,] [After Deductible,] <50% - 90%> of Reasonable Expenses [after <\$5 - \$200> Copayment per visit]. [For SMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible][[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]. [For CMM Benefit, <50% - 100%> of Reasonable Expenses after [Deductible] [[/ and / or / and/or] <\$5 - \$200> Copayment per visit.]] / Deductible waived.]

COVERAGE A--MEDICAL EXPENSES

[Indemnity Plan Limits

[PPO Plan In PPO Limits

[PPO Plan Outside PPO Limits

[Emergency Hospital Services]

<50% - 100%> of Reasonable Expenses [after Deductible] [and after <\$50 - \$500> Copayment per visit]. [If admitted to Hospital, then <50% - 100%> of Copayment Waived.]

<50% - 100%> of Reasonable Expenses [after Deductible] [and after <\$50 - \$500> Copayment per visit]. [If admitted to Hospital, then <50% - 100%> of Copayment Waived.]

<50% - 100%> of Reasonable Expenses [after Deductible] [and after <\$50 - \$500> Copayment per visit]. [If admitted to Hospital, then <50% - 100%> of Copayment Waived.]

[+Payment of Covered Medical Expenses for Preferred Providers is based on the Insurer's negotiated rate. Preferred Providers have agreed to accept the negotiated rate as payment in full.]

[[[*All / <50% - 75%>] Physician Visit Copayments / [*All / <50% - 75%>] of Deductibles] [for an Injury or Sickness] are waived if treatment is received at Recognized Student Health Center or if the initial treatment for an Injury or Sickness is received at Recognized Student Health Center.]

If a Covered Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

[If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Preferred Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Preferred Provider.]

SCHEDULE OF BENEFITS

TABLE 3

COVERAGE A--MEDICAL EXPENSE BENEFITS

BENEFITS LISTED BELOW ARE SUBJECT TO

1. ~~TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;~~

<#.> [TABLE 1 LEVELS OF COVERAGE FOR BASIC MEDICAL EXPENSE BENEFITS, SUPPLEMENTAL MAJOR MEDICAL EXPENSE BENEFITS, AND CATASTROPHIC MAJOR MEDICAL EXPENSE BENEFITS; [AND]]

<#.> [TABLE 2 PLAN TYPE LIMITS (INDEMNITY OR PPO)]

MEDICAL EXPENSES

Eligible Participant and Dependent

[Maternity Care for a Covered Pregnancy

Reasonable Expenses [with <\$100 - \$10,000 Copayment for the delivery of the child of a Covered Pregnancy.] [Conception must have occurred while the Covered Person was insured under the Policy.]

[Inpatient treatment of mental and nervous disorders [including drug or alcohol abuse]	Reasonable Expenses up to <\$500 - \$25,000> [Maximum per Policy Year <u>Period of Coverage</u> / lifetime] [for a maximum period of <30 – 100> days per [lifetime / Policy Year <u>Period of Coverage</u>].]
[Outpatient treatment of mental and nervous disorders [including drug or alcohol abuse]	Reasonable Expenses up to <\$500 - \$25,000> Maximum per [Policy Year <u>Period of Coverage</u> / lifetime].]
[Treatment of drug and alcohol abuse]	[Reasonable Expenses up to <\$500 - \$25,000> Maximum per [Policy Year <u>Period of Coverage</u> / lifetime].] [Included in coverage for Inpatient and Outpatient mental and nervous disorders.] / Maximum of <10 – 100> visits per <6 – 24> month period [and a maximum of <\$25 - \$100> per visit. [<Ten – Thirty> of such visits may be for the benefit of the immediate family].]
[Inpatient and Outpatient treatment of mental and nervous disorders [including drug or alcohol abuse]	Reasonable Expenses up to <\$500 - \$25,000> Maximum per [Policy Year <u>Period of Coverage</u> / lifetime]]
[Outpatient back and spine treatment (including modalities)]	Reasonable Expenses up to <\$250 - \$10,000> Maximum per Policy Year <u>Period of Coverage</u> with a <\$25 - \$200> per visit Maximum and a Maximum of <1 – 5> visits per week]
[Treatment of specified therapies, including acupuncture and Physiotherapy]	[Reasonable Expenses up to <\$500 - \$10,000> Maximum per [Policy Year <u>Period of Coverage</u> / lifetime / Injury or Sickness] on an Inpatient basis / Reasonable Expenses for up to <20 – 60> days Maximum per [Policy Year <u>Period of Coverage</u> / lifetime / Injury or Sickness] on an Inpatient basis. / Reasonable Expenses up to <\$500 - \$10,000> Maximum per [Policy Year <u>Period of Coverage</u> / lifetime / Injury or Sickness] on an Outpatient basis / Reasonable Expenses up to <\$25 - \$100> Maximum per visit subject to a Maximum of <10 – 100> visits [on an Outpatient basis] [if service is prescribed by a Physician and such prescription is for a stated number of visits.] This benefit is per [Policy Year <u>Period of Coverage</u> / lifetime / Injury or Sickness. / Reasonable Expenses up to <\$500 - \$10,000> Maximum combined total for Inpatient and Outpatient care, up to <10 – 100> days immediately following the attending Physician’s release for rehabilitation following a covered Hospital confinement or surgery per [Policy Year <u>Period of Coverage</u> / lifetime / Injury or Sickness.]]
[[Therapeutic termination of pregnancy] [Elective termination of pregnancy]	Reasonable Expenses up to <\$100 - \$1,000> [In PPO] Maximum per Policy Year <u>Period of Coverage</u> [and up to <\$100 - \$1,000> [Outside PPO] Maximum per Policy Year <u>Period of Coverage</u>]]
[Routine nursery care of a newborn child of a covered pregnancy]	Reasonable Expenses up to <\$250 - \$2,000> Maximum per Policy Year <u>Period of Coverage</u>]
[Treatment of Congenital Conditions and conditions arising or resulting directly therefrom]	[Reasonable Expenses. / Reasonable Expenses up to <\$1,000 - \$25,000> Maximum per Policy Year <u>Period of Coverage</u>]]
[Annual cervical cytology screening for women 18 and older]	<50% - 100%> [of] [Reasonable Expenses].]
[Low dose mammography screening[, one baseline mammogram and one mammogram per year].]	<50% - 100%> [of] [Reasonable Expenses].]

TABLE 3 – (Continued)

[Medical treatment arising from participation in [intercollegiate,] [interscholastic][, intramural] [,club] or [professional] sports	Reasonable Expenses up to <\$1,000 - \$100,000> Maximum per [Policy Year <u>Period of Coverage</u> /lifetime / Injury or Sickness] [Injuries from participation in intramural sports are covered as any other Injury]
[Outpatient Laboratory Tests and Xrays]	[Limited to a maximum of <\$100 - \$2,500 per [Injury or Sickness / Policy Year <u>Period of Coverage</u>].]
[CAT Scans and MRI's]	[Reasonable Expenses Limited to a maximum of <\$100 - \$2,500 per [Injury or Sickness / Policy Year <u>Period of Coverage</u>].]
[Vaccinations required by Participating Organization or Institution	<50% - 100%> [of] [Reasonable Expenses.]
[Medical treatment of Injuries sustained as a result of a covered motor vehicle accident	Reasonable Expenses [up to <\$500 - \$100,000> Maximum per [Policy Year <u>Period of Coverage</u> /lifetime / Injury or Sickness]]
[Repairs to sound, natural teeth required due to an Injury	<50% - 100%> of Reasonable Expenses up to <\$50 – \$2,500> per Policy Year <u>Period of Coverage</u> maximum/<\$50 – 300> per tooth]
[Dental Treatment (including extractions) to alleviate pain	<50% - 100%> of Reasonable Expenses up to <\$50 - \$500> per Policy Year <u>Period of Coverage</u>]
[Repair or replacement of an existing prosthetic device	<50% - 100%> of Reasonable Expenses up to <\$50 - \$1,000>. [Not Available in Home Country.]
[Outpatient prescription drugs filled at Student Health Center	[<50% - 100%> of actual charge [after a <\$5 - \$30> Copayment per prescription] / No Charge].]
[Outpatient prescription contraceptives and devices filled at Student Health Center	[<50% - 100%> of actual charge [after a <\$5 - \$30> Copayment per prescription] / No Charge].]
[Outpatient prescription drugs 1. Generic Drugs 2. Brand Name Drugs 3. Injectables	[<50% - 100%> of actual charge / Not Covered. / Prescription Drug Program with the Copayment stated below], [up to a maximum of <\$100 - \$5,000> per Policy Year <u>Period of Coverage</u>].[Limited to a 31 day supply for initial fill or refill.]] All except a <\$5 - \$50> Copayment per prescription All except a <\$5 - \$50> Copayment per prescription] All except a <\$5 - \$50> Copayment per prescription]
[Outpatient prescription contraceptives and devices	Covered under prescription drugs benefit above [and limited to no more than <\$100 - \$1,000> per Policy Year <u>Period of Coverage</u>].
[Professional ground [or air ambulance] service to nearest hospital	Reasonable Expenses [up to <\$100 - \$2,000> per Injury or Sickness]]
[Preventive and primary care services	Reasonable Expenses for unlimited visits for children up to the age of 12 years and Reasonable Expenses for 3 visits per year for minor children ages 12 years up to 18 years of age.]
[Medical treatment received in the Home Country [, if NOT covered by Other Plan]	<50% - 100%> of Reasonable Expenses <u>up to a maximum of</u> <\$250 - \$10,000> Lifetime maximum
[Certain Pre-existing Conditions and Diseases will be considered Covered Sickness from the Effective Date of Coverage	A maximum of <\$100 - \$2,000] per [Policy Year <u>Period of Coverage</u> / Injury or Sickness] will be paid for all medical treatment the following conditions and diseases: malaria, dysentery, tuberculosis, cholera, shigellosis, typhoid fever, typhus, diphtheria, yellow fever, schistosomiasis, and mosquito borne encephalitis.]

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A--MEDICAL EXPENSES

- A. What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable [for any one Injury or Sickness] will not exceed the Maximum Benefit for the Eligible Participant [or the Maximum Benefit for an Eligible Dependent] stated in Coverage A—Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Copayments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, [the Recognized Student Health Center provision] and to all other limitations and provisions of the Policy.
- B. Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group policy administered by the Administrator immediately prior to the ~~Policy Effective~~ **Coverage Start** Date **shown on the Identification Card issued to the Participant**, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance. ~~Any applicable pre-existing condition limitation and waiting period under the prior plan will be waived.~~

~~[If the Covered Person was insured under a group policy previously offered to a Participating Organization or Institution immediately prior to Policy Effective Date of a group policy administered by the Administrator, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance so long as there was continuous coverage from the previous policy to the current policy.]~~

- 1. Physician office visits.**
- 2. Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

If Tests and Xrays are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services there is no additional Copayment for these Tests or Xrays. [A Deductible may apply.] However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

<3.> Emergency Hospital Services. Emergency Hospital Services are Emergency Medical Care delivered in a Hospital emergency room as defined in this Policy. If there is no admission to the Hospital, there will be a Copayment as stated in the Schedule of Benefits.

<4.> [Recognized Student Health Centers:

[The Policy does not cover the cost of treatment or services that are [provided normally without charge by Policyholder' Student Health Center][, covered or provided by the student health fee,] [rendered by an person employed by the Policyholder, including team Doctor and trainers] [or any other service performed at no cost.] No premium charged is charged for any such treatment.]

[If there is a charge for visits to, or medical services, treatments and supplies received from, a Recognized Student Health Center for an Injury or a Sickness, benefits for those visits, medical services, treatments and supplies will be paid at <50% - 100%> of Reasonable Expenses with no Copayment or Deductible.]

[[If the Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a provider (if available) included on the Administrator's list provided to the Recognized Student Health Center. / If the Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a Preferred Provider. If the Covered Person uses the Preferred Provider, medical benefits are paid according to the "Inside PPO" schedule. If the Covered Person chooses not to use the Preferred Provider, medical benefits are paid according to the "Outside PPO" schedule.] [The Copayment and/or Deductible for the initial visit to the Preferred Provider will be waived or reduced if seen by the Recognized Student Health Center first. See Table 2 of the Schedule of Benefits.]]

[C. **Additional Covered General Medical Expenses and Limitations:** These additional Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

<1.> **[Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. [Conception must have occurred while the Covered Person was insured under the Policy.] Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a. A minimum of 48 hours of inpatient care following a vaginal delivery; or
- b. A minimum of 96 hours of inpatient care following delivery by cesarean section.

If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a. Parental education;
- b. Assistance and training in breast or bottle feeding; and
- c. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.]

<2.> **[Annual cervical cytology screening for cervical cancer and its precursor states for women [age 18 and older]:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.] [(Cervical screenings are not subject to the deductible provision)].

<3.> **[Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:

- a. Female Covered Persons are allowed one baseline mammogram;
- b. Female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.);]

<4.> **[Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.]

<5.> **[Diabetic Supplies/Education:** Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.]

<6.> **[Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.]

<7.> **[Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.]

<8.> **[Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:

- a. Reconstruction of the breast on which the mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- c. Prostheses; and
- d. Treatment for physical complications of all stages of mastectomy, including lymphedemas.]

<9.> **[Hormone Replacement Therapy:** If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.]

<D.> **[Basic Medical Expense Benefit (Basic):** The Insurer will pay the provider <50% - 100%> of all Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A. [The Basic Medical Expense Deductible Amount will be reduced to as stated in the Schedule of Benefits if initial treatment is rendered at the Participant's Registered Student Health Center.]

<E.> **[Supplemental Major Medical Expense Benefit (SMM):** The Insurer will pay the provider <50% - 100%> of all additional Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A and after all benefits have been exhausted under the Basic Medical Expense Benefit.]

<F.> **[Catastrophic Major Medical Expense Benefit (CMM):** The Insurer will pay the provider <50% - 100%> of all Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A and after all benefits have been exhausted under the Basic Medical Expense Benefit and Supplemental Major Medical Expense Benefit.]

<G.> **[Home Country Coverage (While Insured):** Expenses incurred within the Covered Person's Home Country while insured under the Policy will be considered as Covered Medical Expenses up to the limits stated in the Schedule of Benefits.]

<H.> **[[Home Country Coverage (Conditions First Diagnosed or Treated in the Country of Assignment) (Mandatory Only):** Expenses incurred within the Covered Person's Home Country, while insured under the Policy, for conditions first diagnosed or treated in the Country of Assignment will be considered as Covered Medical Expenses up to <\$500 - \$25,000>.]

[Expenses incurred within the Covered Person's Home Country while insured under the Policy will be considered as Covered Medical Expenses when:

1. They are Medically Necessary and are authorized after the Covered Person has proven Sickness or Injury in the Country of Assignment; or
2. They are related to a pre-approved medical evacuation and would have been covered had the expenses been incurred in the Country of Assignment.]

[The Covered Person will continue to be covered under the Policy's Medical Treatment Benefits provision during temporary return visits to his/her Home Country. However, the Home Country medical expense coverage is limited to <\$500 - \$25,000> per [Injury or Sickness [and for a maximum accumulation of <30 - 90> days of return visits to the Home Country during the Period of Coverage].

[[All medical expenses incurred in the Home Country are subject to a <\$50 - \$1,000> Deductible.] [After satisfying the Deductible,] the Insurer will pay <50% - 100%> of Reasonable Expenses incurred up to <\$500 - \$25,000> per [Injury or Sickness / ~~Policy Year~~ Period of Coverage]. [Then, the Insurer will pay <50% - 100%> of Reasonable Expenses incurred up to an additional <\$500 - \$50,000> per [Injury or Sickness / ~~Policy Year~~ Period of Coverage].] [Thereafter, the Insurer will

pay <50% - 100%> of Reasonable Expenses incurred up to an additional <\$500 - \$250,000> per [Injury or Sickness / Policy Year-~~Year~~ Period of Coverage].]]

The Insurer will not cover any medical expense incurred in the Home Country after the Home Country medical expense coverage limits described above have been exceeded.

Payment is subject to the Limitations and Conditions on Eligibility for Benefits provision.]

<SECTION 3>
[DESCRIPTION OF COVERAGES
[[COVERAGE B--ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

[Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Covered Persons in any one Accident or disaster shall not exceed the sum of <\$250,000 - \$1,000,000>. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed the above stated amount of indemnity payable for each Covered Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed the above stated amount.]

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.]

<SECTION 4>
[DESCRIPTION OF COVERAGES
COVERAGE C--REPATRIATION OF REMAINS BENEFIT

If Covered Person dies [from a Covered Sickness or Injury], [while [traveling / living] outside of his/her home country [[for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]]], the Insurer will pay the necessary expenses actually incurred[, up to the Maximum Limit shown in the Schedule of Benefits,] for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

No benefit is payable if the death occurs after the Termination Date of the Policy. [However, if the Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Termination Date.] The Insurer will not pay any claims under this provision unless the expense has been approved by the Plan Administrator before the body is prepared for transportation.

[This benefit is available only to Covered Persons who are living outside of their Home Country while engaged in educational activities.]

<SECTION 5>
[DESCRIPTION OF COVERAGES
COVERAGE D--MEDICAL EVACUATION BENEFIT

If an Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services], [while [traveling / living] outside of his/her home country [[for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]]], and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the [nearest appropriate / the Covered Person's choice of] medical facility. This medically-supervised evacuation will be to the [nearest / the Covered Person's chosen] medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services. Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Covered Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

The Insurer will pay Reasonable Charges for escort services if the Covered Person is a minor or if the Covered Person is disabled during a trip and an escort is recommended in writing by the attending Physician and approved by the Insurer.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

If following stabilization, when medically necessary and subject to the Administrator's prior approval, the Insurer will pay for a medically supervised return to the Covered Person's permanent residence or, if appropriate, to a health care facility nearer to their permanent residence or for one-way economy airfare to the Covered Person's point of origin, if necessary.

[For persons in the U.S., transportation home will be paid for only as a result of a Covered Injury or Sickness that prevents the Covered Person from continuing his/her scholastic program or covered trip. [For Covered Dependents not enrolled in an educational program, transportation home will be covered only as a result of a Covered Injury of Sickness which prevents the Covered Dependent from remaining in the U.S. with the Eligible Participant.]]

All evacuations must be approved and coordinated by Administrator designated physicians. Transportation must be by the most direct and economical route.

With respect to this provision only, the following is in lieu of the Policy's Extension of Benefits provision: No benefits are payable for Covered Expenses incurred after the date the Covered Person's insurance under the Policy terminates. [However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 31st day after the date of termination.]

The combined benefit for all necessary evacuation services is listed in Table 1 of the Schedule of Benefits.]

<SECTION 6>
[DESCRIPTION OF COVERAGES
COVERAGE E--BEDSIDE VISIT BENEFIT

If a Covered Person is Hospital Confined due to an Injury or Sickness for more than <7 – 14> days, is likely to be hospitalized for more than <7 – 14> days or is in critical condition,], [while [traveling / living] outside of his/her home country [[for an uninterrupted period of less than <90-~~364~~ 365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]]], the Insurer will [pay / purchase] [up to the maximum benefit as listed in Table 1 of the Schedule of Benefits] for the cost of one economy round-trip air fare ticket to[, and the [meals] [and][hotel accommodations] in,] the place of the Hospital Confinement for one person designated by the Covered Person. Payment for [meals,] ground transportation and other incidentals are the responsibility of the family member or friend.

[With respect to any one trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip.] The determination of whether the Covered Member will be hospitalized for more than <7 – 14 days> or is in critical condition shall be made by the Administrator after consultation with the attending physician. No more than one (1) visit may be made during any ~~12~~ month Period of Coverage. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

[This benefit is available only to Covered Persons who are living outside of their Home Country while [covered under this Plan / engaged in educational activities].]]

<SECTION 7>
[LIMITATIONS

<A.> [Pre-Existing Condition Limitation

[The Insurer does ~~not~~ pay benefits for loss due to a Pre-Existing Condition.]

[The Insurer does ~~not~~ pay benefits for loss due to a Pre-Existing Condition during the first [60 days / 3 months / 6 months / ~~one (1) year / two years~~] of coverage.] [Pre-Existing Conditions will be covered after the Covered Person's coverage has been in force for [60 days / 3 months / 6 months / ~~one (1) year / two years~~]; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.]

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[The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first [60 days / 3 months / 6 months / ~~one (1) year / two years~~] of coverage, except as follows: [The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the first [60 days / 3 months / 6 months / ~~one (1) year / two years~~] of coverage, subject to a maximum benefit of <\$100 - \$10,000> / . The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's pre-existing Sickness during the first [60 days / 3 months / 6 months / ~~one (1) year / two years~~] of coverage, subject to a maximum benefit of <\$100 - \$10,000>.] After the Covered Person has been covered under the Policy for [60 days / 3 months / 6 months / ~~one (1) year / two years~~], Pre-Existing Conditions will be covered the same as any other Injury or Sickness; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.]

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[The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first [60 days / 3 months / 6 months / ~~one (1) year / two years~~] of coverage, except as follows:

1. The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first [30 days / 60 days / 3 months / 6 months / ~~one (1) year~~] of coverage.
2. The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the next [30 days / one (1) month / 3 months / 6 months / ~~one (1) year~~] so long as the Covered Person's coverage is continuous, subject to a maximum benefit of <\$100 - \$10,000>.
3. After the Covered Person has been covered under the Policy for [60 days / 3 months / 6 months / ~~one (1) year / two years~~], then Pre-Existing Conditions will be covered the same as any other Injury or Sickness; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.]]

[This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.]

<B.> [Limitation of Maternity Coverage.

The Policy does not pay benefits for maternity coverage unless conception occurred while the Covered Person was insured under the Policy .]]

<SECTION 8>
GENERAL POLICY EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

- <1.> [Expenses incurred in excess of Reasonable Expenses.]
- <2.> [Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health[, including routine care of a newborn infant][, unless otherwise noted].]
- <3.> [Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury[, unless otherwise noted].]
- <4.> [Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.]
- <5.> [Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.]
- <6.> [Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for in the Policy.]
- <7.> [Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.]
- <8.> [Elective termination of pregnancy.]
- <9.> [Expenses incurred as a result of pregnancy that is not covered.]
- <10.> [For diagnostic investigation or medical treatment for infertility, fertility, or birth control.]
- <11.> [Reproductive and infertility services.]
- <12.> [Expenses incurred for, or related to sex change surgery or to any treatment of gender identity disorders.]
- <13.> [Expenses incurred for Injury resulting from the Covered Person being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. [This exclusion does not apply [to the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]]
- <14.> [Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. [This exclusion does not apply to [the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]]
- <15.> [Organ or tissue transplant.]
- <16.> [Participating in an illegal occupation or committing or attempting to commit a felony.]
- <17.> [For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)]
- <18.> [While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.]
- <19.> [The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.]
- <20.> [Expenses incurred within the Covered Person's Home Country.]
- <21.> [Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, [TMJ dysfunction] or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia[, unless otherwise noted].]
- <22.> [Expenses incurred in connection with weak, strained or flat feet, corns or calluses.]

- <23.> [Diagnosis and treatment of acne [and sebaceous cyst].]
- <24.> [Expenses incurred as a result of [allergy testing], [allergy shots [or serums]], [Immunizations], [vaccinations], or [vitamins].]
- <25.> [Diagnosis and treatment of sleep disorders.]
- <26.> [Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.]
- <27.> [Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.]
- <28.> [Outpatient treatment for specified therapies including, but not limited to, Physiotherapy and acupuncture [which does not follow a covered Hospital Confinement or surgery].]
- <29.> [Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.]
- <30.> [Self-inflicted Injuries while sane or insane; suicide, or any attempt thereat [while sane or insane]. [This exclusion does not apply [to the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]]
- <31.> [Assistant surgeon's fees, except when required by the Hospital or as specifically provided.]
- <32.> [Expenses incurred for any services rendered by a family member or a Covered Person's immediate family or a person who lives in the Covered Person's home.]
- <33.> [[Unless specifically provided for elsewhere under the Policy][, the cost of treatment or services that are [provided normally without charge by Policyholder's Student Health Center][, covered or provided by the student health fee,] [rendered by an person employed by the Policyholder, including team Doctor and trainers] [or any other service performed at no cost.]
- <34.> [Loss due to [war, declared or undeclared][; service in the armed forces of any country or international authority][; riot][; civil commotion][; or acts of terrorism].]
- <35.> [Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.]
- <36.> [Injuries sustained as the result of an Accident involving a three-wheeled motor vehicle and/or off-road four wheeled motorized vehicles.]
- <37.> [Loss arising from
- [a. Participating in any intercollegiate/interscholastic or professional sport, contest or competition;]
 - [b. Participating in any intramural sport competition, contest or competition;]
 - [c. Participating in any club sport competition, contest or competition;
 - [d. Participating in any professional sport, contest or competition;]
 - [e. Traveling to or from such sport, contest or competition as a participant;]
 - [f. While participating in any practice or condition program for such sport, contest or competition;
 - [g. Racing or speed contests;]
 - [h. [Skin/scuba diving], [sky diving], [mountaineering (where ropes are customarily used)], [ultra light aircraft], [parasailing], [sail planning], [hang gliding], [bungee jumping], [travel in or on ATV's (all terrain or similar type vehicles)].]
- <38.> [Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.]
- <39.> [For Medical Benefits, Medical Evacuation, and Repatriation of Remains Benefits: Conditions caused by or contributed by (a) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from

such release of nuclear energy; (b) An Covered Person participating in the military service of any country; (c) An Covered Person participating in an insurrection, rebellion, or riot; (d) Services received for any condition caused by an Covered Person's commission of, or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.]

<40.> [Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.]

<41.> [[For Accidental Death and Dismemberment Benefits:] Conditions caused by or contributed by [(a) an act of war]; [b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy;] [(c) An Covered Person participating in the military service of any country;] [(d) An Covered Person participating in an insurrection, rebellion, or riot;] [(e) Services received for any condition caused by an Covered Person's commission of, or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.]

<43.> Services or supplies that the Insurer considers to be Experimental or Investigative.

<44.> [Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.]

<45.> [Treatment of Mental, Emotional or Functional Nervous Disorders (including nicotine use) or psychological testing except as specifically stated in this Plan. However, medical conditions that are caused by behavior of the Covered Person and that may be associated with these mental conditions are not subject to these limitations.]

<46.> [Hearing aids.]

<47.> [Routine hearing tests except as provided under Preventive and Primary Care.]

<48.> [Outpatient speech therapy.]

<49.> [Outpatient speech therapy.]

<50.> [Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage.]

<SECTION 9> DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Age means the Covered Person's attained age.

[Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.]

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Certificate of Coverage is the document issued to each Eligible Participant outlining the benefits under the Plan.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Reasonable Expenses for Medically Necessary treatment. The percentage the Insurer pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

[Copayment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.]

[Country of Assignment means the country for which the Eligible Participant has a valid visa, if required, and in which he/she is undertaking an educational activity.]

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

1. Administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. Are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, ~~except as stated in the Extension of Benefits provision.~~ A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section <3>.

Covered Person means an Eligible Participant [and any Eligible Dependents] as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person [on a per Injury or per Sickness] ~~[per calendar year]~~ [per ~~Policy Year~~ **Period of Coverage**] basis before certain benefits are payable under the Policy. The Deductible Amounts are stated in the Schedule of Benefits.

[Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.]

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

[Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse **[partner]** and/or his/her unmarried children under age <18 – ~~25~~ **27**> who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who

1. [With a similar visa or passport,] accompanies the Eligible Participant while that person is engaged in [international] educational activities[; and]

<2.> [Is temporarily located outside the Eligible Participant's Home Country as a non-resident alien]; and

<3.> [Has not obtained permanent residency status.]

As used above:

<1.> [The term "partner means an Eligible Participant's spouse or domestic partner.]

<2.> [The term "domestic partner" means a person of the same sex who:

<a.>[Is not married or legally separated;]

<b.>[Has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;]

<c.>[Is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;]

<d.>[Occupies the same residence as the Eligible Participant;]

<e.>[Has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature;] [and]

<f.>[Has entered into a domestic partnership arrangement with the named Insured.]]

<3.> [The term "domestic partnership arrangement means the Eligible Participant and another person of the same sex has any three of the following in common:

<a.>[Joint lease, mortgage or deed;]

<b.>[Joint ownership of a vehicle;]

<c.>[Joint ownership of a checking account or credit account;]

<d.>[Designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or _____ retirement benefits;]

<e.>[Designation of the domestic partner as a beneficiary of the employee's will;]

<f.>[Designation of the domestic partner as holding power of attorney for health care;] [or]

<g.>[Shared household expenses.]]

Eligible Participant means a person who:

1. Is engaged in international educational activities[; and]

<2.> [Is temporarily located outside his/her Home Country as a non-resident alien;] [and]

<3.> [Has not obtained permanent residency status.]

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:

1. Permanently placing the Covered Person's health in jeopardy, or

2. Causing other serious medical consequences; or

3. Causing serious impairment to bodily functions; or

4. Causing serious and permanent dysfunction of any bodily organ or part.

Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time shall not be included in this definition of a medical emergency, unless symptoms suddenly become so severe that immediate medical aid is required.

Experimental or Investigative means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the final determination as to what is Experimental or Investigative.

Group means a preparatory or high school; an institution of higher learning offering a course of general studies leading to a bachelor's degree, master's degree or doctorate; a part of a university offering a specialized group of courses; or an institution offering instruction in a professional, vocational, or technical field.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster received from the Participating Organization or Institution, as applicable. [However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.] †

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

HTH means Highway to Health (d/b/a HTH Worldwide). This is the entity that provides the Covered Person with access to online databases of travel, health, and security information and online information about physicians and other medical providers outside the U.S.]

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the Policy. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Medically Necessary services or supplies are those that the Insurer determines to be **all** of the following:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
2. Provided for the diagnosis or direct care and treatment of the medical condition.
3. Within standards of good medical practice within the organized community.
4. Not primarily for the patient's, the Physician's, or another provider's convenience.

5. The most appropriate supply or level of service that can safely be provided. For Hospital stays, this means acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy.

[Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.]

[Non-hospital Residential Facility means a facility certified by the District or by any state or territory of the United States as a qualified nonhospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. The term "non hospital residential facility" includes any facility operated by the District, any state or territory, or the United States, to provide these services in a residential setting.]

[Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or 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 when, by law, its benefits are excess of those of any private program or other non-governmental program.]

[Out-of-Pocket Limit means the amount of Reasonable Expenses which the Covered Person must pay after which the Insurer pays 100% of the reasonable Expenses, subject to the limits and provisions of the Policy.]

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician's office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

[Outpatient treatment facility means a clinic, counseling center, or other similar location that is certified by the District or by any state or territory as a qualified provider of outpatient services for the treatment of drug abuse, alcohol abuse, or mental illness. The term "outpatient treatment facility" includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.]

[Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.]

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Physiotherapy means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

~~**[Policy Year** means the period beginning on the Participating Organization's or Institution's effective date. It includes the period beginning on the date Covered Person's coverage under the Policy starts. It ends on earlier of the date the Covered Person's insurance under the Policy ends.]~~

Period of Coverage means the period beginning on the Covered Person's effective date. It ends on the earlier of:

1. The date the Covered Person's insurance under the Policy ends; or
2. The last day of the current School Year as defined by the Participating Organization or Institution; or
3. The date the Covered Person returns to his or her Home Country; or
4. 364 days from the Covered Person's effective date at 11:59 PM.

[Preferred Provider means a Hospital, Physician, or other health care provider who has agreed to participate in the PPO and who has agreed to accept negotiated rates for charges for Covered Medical Expenses. Preferred Providers have agreed to accept the negotiated rate as payment in full.]

[Preferred Provider Organization (PPO) means the network(s) of Preferred Providers stated on the Covered Person's identification card.]

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received [up to 60 days / 3 months / 6 months / one (1) year / two years] prior to the Covered Person's effective date of coverage.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. For a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. For a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

[Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students [for a minimum of <10 – 40>] hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider [and is approved as a Recognized Student Health Center by the Administrator].]

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." or "R. P.N." after his/her name.

School Year means the period of time commencing on the [first day of the fall semester and ending on the last day of the spring semester as defined] [date determined] by the Organization or Institution.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Policy.

[Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
 - a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
 - b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.]

[Written Request means a request on any form provided by the Administrator for particular information.]

[11:59:59 p.m. means 11:59:59 p.m. at the Covered Person's location.]

[12:00:01 a.m. means 12:00:01 Eastern Prevailing Time in Washington, DC.]

<SECTION 10> [EXTENSION OF BENEFITS

[No benefits are payable for medical treatment benefits after the Covered Person's insurance terminates. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date:

1. The Confinement ends; or
2. 31 days after the date the insurance terminates; or

3. The end of the current Period of Coverage.]

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[If the Insurer terminates the Policy, coverage will be extended for a Covered Person who:

1. Is Totally Disabled on the date coverage ends[; or]

<2.> [Is pregnant on the date coverage ends if the pregnancy manifested itself while insurance was in force under the Policy].

Coverage under this provision is provided only for Covered Medical Expenses with respect to:

1. A Totally Disabled Covered Person, for the condition causing the Total Disability[; and]

<2.> [A pregnant Covered Person, for that pregnancy, childbirth or miscarriage.]

Coverage so extended will end on the first of the following to occur:

1. The 90th day following termination of the Policy; or

2. The date the Total Disability ends[; or]

<3.> [The end of the pregnancy; or]

<4.> [The end of the current Period of Coverage ~~{52 / 104} week period during which expenses must be incurred to receive benefits under the Policy~~.] 1

Except as stated above, coverage is not provided for any expense incurred after the date the Policy terminates.

This coverage extension will not apply to termination initiated by any Covered Person, Participating Organization or Institution or the Policyholder.]

**<SECTION 11>
[EXTENSION OF COVERAGE**

[Coverage as shown in the Schedule of Benefits will be extended for a Covered Person, provided the appropriate premium has been paid, for a period of <30 - 90 days> after the conclusion of the assignment in the Country of Assignment, but not beyond the end of the current Period of Coverage. Treatment provided within the Covered Person's Home Country will be considered as Covered Medical Expenses while coverage is extended.]

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[Expenses for conditions first diagnosed or treated while in the Country of Assignment incurred in a Covered Person's Home Country within <30 – 120> days after termination of coverage will be considered Covered Medical Expenses [up to <\$1,000 - \$25,000>.]

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[Expenses for conditions contracted as a direct result of the assignment in the Country of Assignment incurred in a Covered Person's Home Country within <30 – 120> days after termination of coverage will be considered Covered Medical Expenses [up to <\$1,000 - \$25,000>.]]

**<SECTION 12>
[EXCESS COVERAGE**

The Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies.

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COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any [policy year / calendar year.] This helps to hold down the costs of health coverage.

COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

The term “plan” applies separately to each policy, contract agreement or other arrangements for benefits or services. The term “plan” also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid. This provision may not be applied to claims less than <\$50 – \$250>, but if additional liability is incurred to raise the small claim above <\$50 – \$250>], the entire liability may be included in the coordination of benefits computations.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If this primary plan’s payment is less than the charge for the allowable expense, then the second-paying (secondary) plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
 - a. First, benefits of a plan covering persons as an employee, member, or subscriber.
 - b. Second, benefits of a plan of an active worker covering persons as a dependent.
 - c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
 - a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
 - b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
 - c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
 - d. When the parents are separated or divorced and the parent with custody has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
 - f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.

4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits.
5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
 - a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. When rules 2 through 5 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by the Insurer, the Insurer has the right to pay the other plan any amount the Insurer deems necessary to satisfy the Insurer's obligation under these COB rules.

Right of Recovery. If the amount of the Insurer's benefit payment is more than the amount needed to satisfy the Insurer's obligation under these COB rules, the Insurer has the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. The Insurer has the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as the Insurer deems necessary; and
2. Any person claiming benefits under this plan must give the Insurer any information necessary to carry out this provision.]

**<SECTION 13>
ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE**

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1—Eligible Classes. [He/she must not be insured under the Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.]

Enrollment for Coverage: An Eligible Participant must enroll for coverage by completing an enrollment form and paying any required premium prior to the date he or she arrives in the Country of Assignment. ~~will be eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in his/her enrollment form.~~ [If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; [or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.]

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

- ~~1. The effective date of the Policy; or~~
- ~~<2.> [The Participating Organization's or Institution's Effective Date;]~~
- <1.> The effective date shown on the Insurance Identification Card, if any;
- <2.> The date the requirements in Section 1—Eligible Classes are met; or
- <3.> The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide [except whenever the Covered Person is in his/her Home Country]. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

[For Transfers Only: If a Covered Person transfers from a Group which has coverage under a policy issued on the same form as this plan of insurance to another Group which also has coverage under the same policy form, or transfers from one plan to another under the same policy, ~~and coverage is continuous, then coverage is continued between the two plans of insurance. A Covered Person~~ he/ she will be covered under the newer plan for medical conditions which first arise on or after the transfer date. A Pre-Existing Condition will not be covered under the newer plan until the benefit period expires for such condition under the prior plan (the plan under which the Covered Person was insured prior to the date of transfer). At that time, the Pre-Existing Condition will be covered under the newer plan. Benefit payments for Pre-Existing Conditions shall be the lesser of:

1. The unused portion of the maximum benefit applicable to the covered medical condition under the prior plan; or
2. The maximum benefit applicable to the covered medical condition under this plan.

Both 1 and 2 above are subject to the benefit periods, Deductibles, and Coinsurance as defined in the respective policies.]

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
- <2.> [The Participating Organization's or Institution's Termination Date;]
- <3.> The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
- ~~<4.> The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;~~
- <4.> The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
- <5.> The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
- <6.> The premium due date for which the required premium has not been paid, subject to the Grace Period provision.
- <7.> The end of any Period of Coverage.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage [or if the enrollment form contained inaccurate or misleading information].

Coverage will end at 11:59:59 p.m. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

At the end of any Period of Coverage an Eligible Participant may re-enroll by completing an enrollment form and paying any required premium.

[When an Eligible Dependent's Coverage Starts: An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, entry into or departure from the Country of Assignment. An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

1. ~~The effective date of the Policy; or~~
- ~~<2.> [The Participating Organization's or Institution's Effective Date;]~~
- <1.> The effective date of the Eligible Participant's insurance;
- <2.> The effective date shown on the insurance identification card, if any;
- <3.> The date the eligibility requirements in this section are met; or

<4.> The date the completed enrollment form, if any, and premium are received by the Insurer. Thereafter, the insurance is effective 24 hours a day, worldwide [except whenever the Covered Person is in his/her Home Country.] In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.]

[When an Eligible Dependent's Coverage Ends. An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates; or

<2.> [The Participating Organization's or Institution's Termination Date;]

<3.> The date the Eligible Participant is no longer covered under the Policy;

~~<4.> [The end of the term of coverage shown on the enrollment form, if any, including any requested extension;]~~

<4.> 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country;

<5.> The date the Covered Person requests cancellation of coverage (the request must be in writing);

<6.> The premium due date for which the required premium has not been paid, or

<7.> The date on which the dependent ceases to meet the eligibility requirements.

<8.> The end of any Period of Coverage.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.]

At the end of any Period of Coverage an Eligible Participant may re-enroll his or her Eligible Dependents by completing an enrollment form and paying any required premium.

<SECTION 14>

[COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits. ["Expenses for Routine nursery care" of a newborn infant of a covered Pregnancy are covered up to the limits, if any, shown in the Schedule of Benefits.]

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of placement for adoption, provided the Eligible Participant's coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement.

[Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.]

[Expenses for routine nursery care means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.]

In order to continue the coverage of a newborn child beyond the 31st day following his/her date of birth or of an adopted child beyond the 31st day following his/her placement:

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 31 days from the date of birth or placement.]

<SECTION 15>
[PREMIUM FOR INDIVIDUAL ENROLLMENT]

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid monthly, in three month increments quarterly, in six month increments semi-annually, annually, or for a Period of Coverage specified term, as arranged with the Administrator. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Covered Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Renewing Coverage: The benefits provided by this Certificate terminate at the end of the current Period of Coverage. At the end of any Period of Coverage an Eligible Participant, if [an International Student Eligible Participant] [or] [a Study Abroad Student Eligible Participant], may re-enroll by completing an enrollment form and paying the required premium. ~~Coverage for all Covered Persons shall be continuous if the acceptable renewal form and premium are received by the Insurer prior to the expiration of coverage.~~ Premiums will be based upon the attained age of the Covered Person at the time of renewal. Any Covered Person whose coverage under the Policy lapses may re-enroll and shall be subject to all Policy exclusions as of any subsequent effective date.

Grace Period: There is a 31 day grace period after the premium due date in which to pay the required premium. The Policy and affected coverage will stay in force during the grace period. The grace period does not apply to payment of the first premium or the last premium when the Covered Person requests to terminate coverage. The Covered Person is liable for all premium unpaid, including any part or entire premium due through the grace period.

Cancellation Requirements: Cancellation will only be allowed if one of the following three requirements are met:

1. Proof of ineligibility is provided; or
2. Claims have not been submitted; or
3. Cancellation occurs within the first 60 days from the effective date or from the effective date of the most recent ~~renewal date~~ Period of Coverage; and
4. The Covered member requests cancellation in writing.

A full refund will be given. A \$50 administration fee deducted from the premium will be charged. If cancellation is after 60 days, 100% of the premium is earned and a refund will not be given.]

<SECTION 16>
CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Policy which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to \$1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

[All benefits payable under the Policy shall be payable to the Insured or to his/her designated beneficiary or beneficiaries, or to his/her estate. If the Insured is a minor, benefits may be payable to his/her parents, guardian, or other person actually supporting him/her, or to a person or persons upon whom such minor is chiefly dependent upon for support and maintenance.]

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

<SECTION 17> GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Participating Organization or Institution, copies of which are attached to and made a part of the Policy. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Policy has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Policy unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after <1 - 2> year[s] from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Policy.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers' compensation. The Policy does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Policy in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

Grievance Procedures: If the Covered Person's claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

The Covered Person has the right to appeal any denial of a claim for benefits by submitting a written request for reconsideration with the Insurer. Requests for reconsideration must be filed within 60 days after receipt of the written notification of denial. When the Insurer receives the Covered Person's written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Covered Person's satisfaction, he/she may request a second review of the claim by sending the Insurer a written request for a second reconsideration. This written request must be filed within 60 days of the Eligible Participant's receipt of the Insurer's written notification of the result of the first review. If the issue involves a dispute over the coverage of medical services, or the extent of that coverage, the second review will be completed by physician consultants who did not take part in the initial reconsideration. The Covered Person will be informed, in writing, of the Insurer's final decision.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Eligible Participant or the Group because the Eligible Participant, the Group, or any person acting on the Eligible Participant's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

The Insurer will meet any Notice requirements by mailing the Notice to the Group at the billing address listed on our records. The Group will meet any Notice requirements by mailing the Notice to:

HM LIFE INSURANCE COMPANY
120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433

Dispute Resolution

All complaints or disputes relating to coverage under this Plan must be resolved in accordance with the Insurer's grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by the Insurer that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Covered Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer propose to resolve the grievance.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Insured Participant and his/her Insured Dependents or the Group because the Insured Participant's, the Group's, or any person's action on the Covered Person's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.