

SERFF Tracking Number: TRST-127168378 State: Arkansas
Filing Company: Trustmark Life Insurance Company State Tracking Number: 48769
Company Tracking Number: 11.00168
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: STUBLK R11-09 [MP]
Project Name/Number: Student Health Policy Paragraph and Certs/11.00168

Filing at a Glance

Company: Trustmark Life Insurance Company

Product Name: STUBLK R11-09 [MP]

TOI: H04 Health - Blanket Accident/Sickness

Sub-TOI: H04.001 Student

Filing Type: Form

SERFF Tr Num: TRST-127168378 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48769

Co Tr Num: 11.00168

Author: Jeri Jacks

Date Submitted: 05/13/2011

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 05/13/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Student Health Policy Paragraph and Certs

Project Number: 11.00168

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Blanket

Filing Status Changed: 05/13/2011

State Status Changed: 05/13/2011

Created By: Jeri Jacks

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

This is a filing of two matrix insert pages and two certificates for a student health insurance product. This student health product was approved by your Department under file number 46030 (SERFF # TRST-126691076) on 7/28/2010, that filing included the policy, inbound certifidate, outbound certificate, offer form and application.

We inadvertently failed to include the bracketed offer language for the hearing aid offer and the TMJ offer. This filing is being made to remedy that omission. This filing includes the insert pages from the policy containing the covered

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expenses and the exclusions and the certificates for inbound (international) students and outbound (domestic) students. The policy insert page CE R11-09 AR (R1) and the certificate (page 8 of the inbound certificate and page 6 of the outbound certificate) contain the offer language. Policy insert page EXCL R11-09 AR (R1) and page 12 of the inbound certificate and page 11 of the outbound certificate contain the exclusion with hearing aid bracketed, so it can be removed if the offer is accepted.

If you have any questions, please contact me at (800) 666-6977 extension 34205 or at my email address jjacks@trustmarkins.com.

Company and Contact

Filing Contact Information

Jeri Jacks, Regulatory Advocacy Analyst jjacks@trustmarkins.com
 400 Field Drive 800-666-6977 [Phone] 34205 [Ext]
 Lake Forest, IL 60045 847-615-3872 [FAX]

Filing Company Information

Trustmark Life Insurance Company CoCode: 62863 State of Domicile: Illinois
 400 Field Drive Group Code: 276 Company Type:
 Lake Forest, IL 60045 Group Name: State ID Number:
 (800) 666-6977 ext. [Phone] FEIN Number: 36-3421358

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: The fee is \$50 per form and there are 4 forms in this filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Trustmark Life Insurance Company	\$200.00	05/13/2011	47566066

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/13/2011	05/13/2011

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Disposition Date: 05/13/2011

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Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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
Form	Covered Expenses	Approved-Closed	Yes
Form	Exclusions and Limitations	Approved-Closed	Yes
Form	Certificate for Inbound Students	Approved-Closed	Yes
Form	Certificate for Outbound Students	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CE R11-09 AR (R1)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/13/2011	CE R11-09 AR (R1)	Matrix	Covered Expenses	Initial			CE R11-09 AR (R1).pdf
Approved-Closed 05/13/2011	ECXL R11-09 AR (R1)	Matrix	Exclusions and Limitations	Initial			EXCL R11-09 AR (R1).pdf
Approved-Closed 05/13/2011 (R1)	STUBLK-INBD AR	Certificate	Certificate for Inbound Students	Initial			AR Inbound certificate final 5-13-11.pdf
Approved-Closed 05/13/2011 (R11)	STUBLK-OTBD AR	Certificate	Certificate for Outbound Students	Initial			AR Outbound certificate final 5-13-11.pdf

COVERED EXPENSES

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

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

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

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

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

1. charges for diagnosis and treatment by a Doctor, registered nurse (not a Close Relative of or same legal residence as the Insured Individual);
2. charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges;
3. charges by a Hospital for outpatient medical care received on an outpatient basis and outpatient medical supplies which are used on the premises of a Hospital;
4. charges for home health care performed by a licensed home health agency when prescribed by a Doctor in lieu of Hospital services, provided the Hospital services would have been Covered Expenses under the Policy;
5. charges for laboratory, x-ray, and other diagnostic examinations;
- [6. charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay up to [100%] of charges for such drugs used on an inpatient basis [or dispensed by a Student Health Center] and [50%] of charges for such drugs [not dispensed by a Student Health Center Physician and] which are used for outpatient treatment;]
- [6. [100%] of the charges for outpatient prescription drugs dispensed by a preferred pharmacy subject to the following co-pays:
 - \$10 for each 30 day supply of generic prescription drug
 - \$30 for each 30 day supply of preferred product prescription drug
 - \$50 for each 30 day supply of non-preferred product description drugInpatient prescription drugs will be subject to the plan's coinsurance levels; [90% In-Network/ 70% Out-of Network).

The Insured Individual will be responsible for paying the difference, plus co-pay, if the Insured Individual requests a brand name drug.

Preferred pharmacies are those pharmacies participating in the [Express Scripts] preferred network. To find a participating pharmacy in your area call [1-800-451-6245] or visit www.lewemark.com to find a pharmacy.]

NOTE: The above benefit is for inbound plans only.

Outpatient prescription drugs are subject to a policy year maximum of [\$500].

7. charges for emergency professional ambulance service by ground or air to a Hospital [up to a maximum benefit of [\$500.00][\$1,000]] (see Medical Evacuation Benefit below for air service to an Insured Individual's home country);
8. charges for the following types of orthopedic or prosthetic devices or Hospital equipment:
 - a. man-made limbs or eyes for the replacing of natural limbs or eyes;
 - b. casts, splints or crutches;
 - c. purchase of a truss or brace;
 - d. oxygen and rental of equipment for giving oxygen;
 - e. rental (up to the purchase price) of a wheelchair or Hospital bed;
 - f. rental of dialysis equipment and supplies;
 - g. colostomy bags and ureterostomy bags; and
 - h. two external post-operative breast prostheses.

NOTICE: The Policy will not cover rental charges for equipment in excess of the purchase price of the equipment.

9. charges for one routine baseline or screening mammogram in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation;
- [[10.] charges for one routine pap smear in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation;]
- [[11.] charges for prescription oral contraceptives dispensed by a Student Health Center or a licensed pharmacist; the Policy will pay up to [50%];]
- [[12.] hospital or ambulatory surgical center facility charges and anesthesia charges for dental procedures provided to a Covered Person if the treating provider has certified that because of the patient's age, condition or problem, such hospitalization and general anesthesia is required to provide safe and effective treatment; and
 - a Dependent under seven (7) years of age if two (2) dentists licensed in the state have determined the Dependent requires, without delay, necessary treatment for a significantly complex dental condition; or
 - The Covered Person is a person diagnosed with a serious mental or physical condition; or
 - the Covered Person has a significant behavioral problem as determined by their physician.Treatment is subject to all terms, conditions, exclusions and benefit maximums of this Plan, including deductible, coinsurance, and co-pays.
- [[13.] charges for Medically Necessary medical foods and low protein modified food products administered under the direction of a Physician for Covered Persons inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism after the Covered Person has exceeded \$2,400 worth of expenses for these food products during the Year.
- [[14.] charges for treatment of loss or impairment of speech or hearing.

- [15.] charges for In-vitro fertilization procedures, including cryopreservation, for the Insured Individual and the Insured Individual's spouse, if an Insured Individual, if all the following conditions are met:
- the patient and patient's spouse have a history of unexplained infertility of at least 2 years; or the infertility is associated with one or more of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol; blockage of, or surgical removal of, one or both fallopian tubes except due to voluntary sterilization, or abnormal male factors contributing to the infertility;
 - the patient's oocytes are fertilized with her spouse's sperm;
 - the patient has been unable to attain a successful pregnancy through other applicable treatments for which coverage is provided under the Certificate; and
 - the in-vitro fertilization procedure is performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the Department that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.
- Covered Charges related to in-vitro fertilization are subject to a [15,000] lifetime maximum.
- [16.] charges for Medically Necessary cancer treatment drugs and their administration. If the drug is not approved by the United States Food and Drug Administration for use in the treatment of cancer, it will be covered if the drug is recognized as safe and effective for treatment of that specific type of cancer being treated in one of the following standard reference compendia:
- the American Hospital Formulary Service drug information,
 - the National Comprehensive Cancer Network Drugs and Biologics Compendium,
 - the Elsevier Gold Standard's Clinical Pharmacology, or
 - Two articles from medical literature, which have not had their recognition of the drug's safety and effectiveness contradicted in clear and convincing evidence.
- [17.] charges for at least one (1) screening per year for any male Insured Individual forty (40) years of age or older according to the National Comprehensive Cancer Network guidelines. This coverage shall not be subject to Deductibles.
- [18.] charges for treatment of Mental or Nervous Disorders, including Drug Dependency, same as any other physical Medical Condition.
- [19.] Children's Preventive Health Care Services - Benefits will be paid for visits at approximately the following ages: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years. Benefits for all Children's Preventive Health Care Services, other than immunizations, will be payable at the same Deductible, Copayment and maximum amounts as apply to similar services covered under the Policy. Benefits will not exceed the level established by the Arkansas Medicaid Program for the same service or supply. Immunizations given during Children's Preventive Health Care Service visits are exempt from any Deductible or Copayment.
- [20.] [Hearing aids – The coverage provided shall not be for less than \$1400.00 per ear for each three-year period and shall not be less than \$1400.00 per ear beginning on the first day of coverage. Coverage shall not be subject to policy deductibles or copayment requirements.]
- [21.] [Treatment of bone and joints of the face, head and neck (TMJ) - Coverage shall be provided for medically necessary diagnosis and treatment , both of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect,

or pathology. Coverage includes surgical and nonsurgical procedures. This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.]

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

The maximum Physiotherapy Benefit is [\$500][\$1,000] in any consecutive 12-month period. The maximum benefit per visit after satisfaction of the applicable [Copayment][Deductible] is [\$50] for the first visit and [\$25] thereafter.

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

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

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

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

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

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

Interscholastic and Intercollegiate Sports Benefit: Benefits will be payable up to a maximum benefit of [\$10,000] arising out of practice for or participation in interscholastic or intercollegiate sports in any consecutive 12 month period.

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

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

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

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

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

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

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

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

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

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

- [4.] for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, [abortion (except spontaneous and non-elective abortion),] circumcision [(except as covered under the Newborn Infants - Well Baby Care provision)], learning disabilities, immunizations, obesity, allergy tests, vitamins, and antitoxins;
- [5.] for routine physical or health examinations, unless specified in the policy;
- [6.] for any care in connection with the teeth, gums, jaw, or structures directly supporting the teeth; myofacial pain; or temporomandibular joint dysfunction, except the Policy will cover injury to natural teeth resulting from an Injury up to a maximum benefit of [\$100] per tooth [and an overall maximum benefit of [\$500]], per Accident;
- [7.] in excess of the Reasonable and Customary charge;
- [8.] for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from:
 - a. an Injury;
 - b. a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or

- c. a mastectomy (refer to the Post-Mastectomy Coverage provision);
- [9.] for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
- [10.] for [hearing aids,] eye glasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery;
- [11.] for Injury or Bodily Infirmity if covered to any extent under: any occupational benefit plan; Worker's Compensation or similar law; medical payments under individual automobile insurance (except for no-fault auto insurance);
- [12.] [for birth control, including surgical procedures and devices;]
[for birth control devices and surgical procedures;]
- [13.] for Injury arising out of practice for or participation in professional sports;
- [14.] [for medical care, treatment, supplies or services in excess of [\$10,000] arising out of practice for or participation in interscholastic or intercollegiate sports in any consecutive 12 month period;]
- [15.] for medical care, treatment, services, and supplies for which no charge is made or no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
- [16.] for intentionally self-inflicted Injury or Bodily Infirmity, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmity resulting from taking part in the commission of an assault or felony;
- [17.] for diagnosis, treatment, and all other care related to infertility;
- [18.] for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
- [19.] for Injury or Bodily Infirmity from a Mental or Nervous Disorder, alcoholism or drug dependency; except that benefits will be paid for treatment up to (a) an aggregate limit of [30] [10] days of inpatient care in any consecutive 12 month period payable at [100%] after the [Deductible] [Copayment] with respect to a mental or nervous disorder or drug dependency, and (b) outpatient treatment up to a benefit limit of [10] [3] outpatient visits in any consecutive 12 month period, payable at [100%] after the [Deductible] [Copayment] with respect to a mental or nervous disorder, alcoholism, or drug dependency;
- [20.] for Injury or Bodily Infirmity resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license[in the state where the where the Individual Insured primarily resides while attending school];
- [21.] for Injury or Bodily Infirmity resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
- [22.] for medical care, treatment, services, or supplies normally given without charge and provided by employees or Doctors employed by, under contract with, or retained by the Policyholder [unless provided in a Student Health Center by its employees];

- [23.] for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy;
- [24.] for the treatment of sex transformation surgery and related services, or the reversal thereof;
- [25.] for medication prescribed as a smoking deterrent;
- [26.] for the treatment of Alopecia (loss of hair);
- [27.] for the treatment of Acne;
- [28.] for Anorectics (any drug used for the purpose of weight control);
- [29.] for medical and surgical treatment of excessive sweating (Hyperhidrosis);
- [30.] for the treatment of benign Gynecomastia (abnormal breast enlargement in males);
- [31.] for the treatment (including cutting or removing) of toe nails or superficial lesions of the feet including corns, calluses and Heperkeratoses, other than removal of nail matrix or root.
- [32.] for treatment of any Injury or Bodily Infirmary sustained while the Insured Individual is under the influence of illegal narcotics or a non-prescribed controlled substance, including alcohol.

LEWERMARK
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**COVERAGE FOR INTERNATIONAL STUDENTS THAT EVERYONE CAN
UNDERSTAND**

Making a World of Difference

Benefits for Accident and Sickness for: [Name of school]

- [100% coverage after Copayment for most expenses]
- [[\$50] Plan Deductible per cause]
- 100% coverage after Deductible for most expenses]
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Trustmark Life Insurance Company

ELIGIBILITY

The LowerMark international students medical benefits plan is designed for international and practical training students. The Plan is available by virtue of a master blanket insurance policy issued by the Company, Trustmark Life Insurance Company, to a university, college or other educational organization (the "Policyholder").

Eligible Student: An "Eligible Student" means any international and practical training student [and] [visiting faculty][scholar] [or][exchange visitor] of the Policyholder who meets all of the following:

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

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

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

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

1. home study.
2. correspondence courses.
3. internet courses.
4. television courses.

Inbound international students must meet the criteria established, published, and updated from time to time by the Student and Exchange Visitor Program administered by the Department of U.S. Immigration and Customs Enforcement.

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

To be an Insured Individual under the Policy, the student must have paid the required premium. The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, it's only obligation is to refund premium less any claims paid.

[Eligible Dependent: An "Eligible Dependent" means a dependent of an Eligible Student who [has a current passport or visa][;] [is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien in the United States][;] is the Eligible Student's lawful spouse or unmarried Child (natural child, step-child, adopted child or child placed for adoption under age 19 and dependent upon the Eligible Student or the student's spouse for the Child's main support and care); resides with the Eligible Student; and is enrolled for coverage under the policy at the same time the Eligible Student enrolls or within 31 days of first becoming eligible. Dependent children born in the United States are also Eligible Dependents. A disabled, unmarried Child of an Insured Student is also an Eligible Dependent if all the following conditions are met:

1. The Child became disabled before reaching age [19];
2. The Child is incapable of self-sustaining employment because of a developmental disability or physical handicap and is chiefly dependent upon the Insured Student for support and maintenance;
3. The student remains insured under the Policy;

4. The Child's premium, if any, continue to be paid;
5. The Insured Student furnishes to the Company, a statement of disability. The Company's approval of such statement is required for the Child to continue eligibility; and
6. The Insured Student provides proof satisfactory to the Company of the Child's disability and dependent status when requested by the Company. Such proof shall be without cost to the Company. The Company will not ask for proof more often than once a year after the two-year period following the Child's attainment of age [19].]

[Extended Coverage applies to Eligible Dependents of newly enrolled students who arrive in the United States prior to the commencement of their studies.]

[A student covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:

1. the request is made prior to the termination of extended coverage;
2. premium is promptly paid for the additional 30 days of coverage; and
3. the Insured Student and covered dependents, if any, remain in the United States.]

[Coverage for an Eligible Dependent of an Eligible Student will be effective 30 days prior to the date of any school term start date.]

EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Provided the correct premium is received timely and the Eligible Student and/or Eligible Dependent is properly enrolled, coverage will be effective:

1. on the first day of the school term for which coverage is applied for if the Eligible Student became an Eligible Student on the first day of the school term and applies within the first 60 days of the school term.
2. on the first day of becoming an Eligible Student if such day is after the first day of the school term, and enrollment is made within 60 days of becoming an Eligible Student.
3. for an Eligible Student who is eligible for Extended Coverage, 30 days prior to the first day of the school term if the Eligible Student applies for coverage within the first 60 days of the school term.
4. on the first day an Eligible Student suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss.
5. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Student or after becoming an Eligible Dependent, or after an Eligible Student or an Eligible Dependent suffers an involuntary loss of other coverage.
6. for an Eligible Dependent child, on the date of birth, adoption or Placement for Adoption, if enrollment is made within 31 days of such event.
7. for an Eligible Dependent, on the first day of the first month following the Dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured student is covered under the Policy.
8. for an Eligible Dependent, on the first day of the first month following the date the Dependent first meets the definition of "Eligible Dependent" if such Dependent did not qualify at the time the Insured Student was enrolled under the Policy. Enrollment must be made within 31 days of becoming eligible

[Extended Coverage applies to newly enrolled students who arrive in the country in which the student is attending school prior to the commencement of their studies.] [Coverage for an Eligible Student under Extended Coverage will be effective 30 days prior to the date of any school term start date.] [Coverage for an Insured Individual under Extended Coverage will terminate 30 days following graduation or completion of an educational program provided the Insured Individual remains in the country in which such individual is attending school.]

[A student covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:

1. the request is made prior to the termination of extended coverage;
2. premium is promptly paid for the additional 30 days of coverage; and
3. the Insured Student and covered dependents, if any, remain in the country in which the student

attended school.]

[For Eligible Dependents:

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

1. the date the Eligible Student's coverage begins with respect to each Eligible Dependent the student has at time of his/her enrollment;
2. the date of birth, if enrollment is made within 90 days of such event or by the next premium due date, whichever is greater;
3. for adopted children, from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after birth;
4. on the first day of the first month following the dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured Student is covered under the Policy;
5. on the first day an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
6. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Dependent or after an Eligible Dependent suffers an involuntary loss of other coverage; or
7. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

Dependent coverage cannot become effective prior to the effective date of the Eligible Student's coverage.

TERMINATION DATE OF INDIVIDUAL COVERAGE

Coverage will automatically terminate on the earliest of:

1. The date the Policy terminates;
2. The last day of the period for which premium has been timely paid according to Policy provisions;
3. The date the Insured Individual is no longer eligible for coverage;
4. For an Insured Individual under Extended Coverage, upon the Eligible Student's graduation or completion of an educational program and in preparation for the resulting departure from the United States, coverage will terminate 30 days following graduation or completion of an educational program, provided the student and his or her covered Dependents remain in the United States during that 30-day period.
5. The date requested by the Insured Individual approved by the Policyholder in writing that is no sooner than 5 days after the date the Company or its authorized administrator receives written notice;
6. The date the Insured Individual departs the United States for the Student's home country or country of regular domicile.

To avoid a break in coverage, (and another pre-existing condition limitation period), students should make sure coverage is in place and paid for when taking a term off from school, even if the student is leaving the country. Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from this Policy to group coverage provided under another plan.

[MEDICAL EXPENSE BENEFITS

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

Each Eligible Dependent covered under the international Policy has a Major Medical Benefit maximum per Accident or Sickness of [\$25,000]. In no event will the benefit maximum for all Accidents and Sickness exceed [\$25,000] in any consecutive 12-month period.]

[Each Insured Individual has a Major Medical Benefit maximum of [\$50,000] per Accident or Sickness, but not exceeding [\$50,000] for all Accidents and Sickness in any consecutive 12 month period.]

[Copayments and Coinsurance

A Copayment will be applied to Covered Expenses as follows:

1. For charges from a Physician, Covered Expenses will be paid at:
 - a. [100%] without application of a Copayment for services provided to an Insured Student at a Student Health Center;
 - b. [100%] after the Insured Individual pays a [\$25] Copayment per visit for services provided by a Participating Provider;
 - c. [80%] after the Insured Individual pays a [\$25] Copayment per visit for services provided by a Physician who is not a Participating Provider.
2. For charges incurred at a Hospital (including inpatient and outpatient services), Covered Expenses will be paid at:
 - a. [100%] after the Insured Individual pays a [\$100] Copayment per admission for services provided by a Participating Provider;
 - b. [80%] after the Insured Individual pays a [\$100] Copayment per admission for services provided by a Hospital which is not a Participating Provider.
3. For charges incurred at a Hospital for emergency room care, Covered Expenses will be paid at:
 - a. [100%] after the Insured Individual pays a [\$50]** Copayment per admission for services provided by a Participating Provider;
 - b. [80%]* after the Insured Individual pays a [\$50]** Copayment per admission for services provided by a Hospital which is not a Participating Provider.

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

** This Copayment will not apply if the Insured Individual is confined in a Hospital immediately after the visit.]

[Deductibles

The Deductible is the amount of Covered Expenses the Insured Individual must pay per Accident or Sickness before Benefits are paid. Benefits will be paid at [100%] after satisfying the following Deductible amounts:

1. With respect to the Insured Student there will be a [\$100] Deductible per Accident or Sickness.
2. With respect to the Insured Individual who is the Eligible Dependent, there will be a [\$100] Deductible per Accident or Sickness.
3. With respect to any Insured Individual, there will be an additional [\$50] Deductible per Sickness before a benefit is payable for Covered Expenses which are incurred for visits to a Hospital emergency room. Such Deductible shall not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.]

Benefits will be paid at the levels described above unless stated otherwise.

INSURING CLAUSE

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

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

[Out-of-Pocket Expense Maximum

When [\$3,000] in Out-of-Pocket Expenses has been paid by an Insured Individual during a calendar year, the [80%] level of benefit payments, if otherwise applicable, will automatically increase to 100% for additional Covered Expenses incurred by that Insured Individual during the

remainder of that calendar year, and Copayment charges will no longer apply. An Out-of-Pocket Expense is the [20%] share of any otherwise Covered Expense and Copayment amounts which an Insured Individual pays.]

Medical Benefits

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable as stated above for a Covered Expense if: (1) the [Copayment][Deductible] requirement is met; (2) the expense is incurred due to a covered Injury or Bodily Infirmary; and (3) the Insured Individual has not exceeded the Major Medical Benefit maximum for the Accident or Sickness for which the expense is incurred, or for all Accidents or Sickness in any consecutive 12 month period. Covered Expenses under the Policy are limited to the following types of expenses prescribed by a Physician for therapeutic treatment of covered Injury or Bodily Infirmary when the fees for such are Reasonable and Customary:

1. Charges for diagnosis and treatment by a Doctor or registered nurse (not a close relative of or same legal residence as the Insured Individual);
2. Charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges;
3. Charges by a Hospital for medical care received on an out-patient basis and outpatient medical supplies used on the premises of a Hospital;
4. Charges for home health care performed by a licensed home health agency when prescribed by a Physician in lieu of Hospital services, provided the Hospital services would have been Covered Expense under the policy.
5. Charges for laboratory, x-ray, and other diagnostic examinations;
- [6. Charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay [100%] of charges for such drugs used on an inpatient basis [or dispensed by a Student Health Center and [50%] of charges for such drugs [not dispensed by a Student Health Center and] used for outpatient treatment;]
- [6. [100%] of the charges for outpatient prescription drugs dispensed by a preferred pharmacy subject to the following co-pays:
 - \$10 for each 30 day supply of generic prescription drug
 - \$30 for each 30 day supply of preferred product prescription drug
 - \$50 for each 30 day supply of non-preferred product description drug

Inpatient prescription drugs will be subject to the plan's coinsurance levels; [90% In-Network/ 70% Out-of Network).

The Insured Individual will be responsible for paying the difference, plus co-pay, if the Insured Individual requests a brand name drug.

Preferred pharmacies are those pharmacies participating in the [Express Scripts] preferred network. To find a participating pharmacy in your area call [1-800-451-6245] or visit www.LewerMark.com to find a pharmacy.]

Outpatient prescription drugs are subject to a policy year maximum of [\$500].]

7. Charges for emergency professional ambulance service by ground or air to a Hospital [up to a maximum benefit of [\$500]] (see Medical Evacuation Benefit for air service to an Insured Individual's home country);
8. Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
 - a. man-made limbs or eyes for the replacing of natural limbs or eyes;
 - b. casts, splints or crutches;
 - c. purchase of a truss or brace;
 - d. oxygen and rental of equipment for giving oxygen;
 - e. rental of a wheelchair or hospital bed;
 - f. rental of dialysis equipment and supplies;
 - g. colostomy bags and ureterostomy bags; and
 - h. two external post-operative breast prostheses.

NOTICE: The policy will not cover rental charges for equipment in excess of the purchase price of the equipment;

9. charges for one routine baseline or screening mammogram in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation;
10. charges for one routine pap smear in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation;]
- 11.charges for prescription oral contraceptives dispensed by a Student Health Center or a licensed pharmacist; the Policy will pay up to [50%];]

- [12.] hospital or ambulatory surgical center facility charges and anesthesia charges for dental procedures provided to a Covered Person if the treating provider has certified that because of the patient's age, condition or problem, such hospitalization and general anesthesia is required to provide safe and effective treatment; and
- a Dependent under seven (7) years of age if two (2) dentists licensed in the state have determined the Dependent requires, without delay, necessary treatment for a significantly complex dental condition; or
 - The Covered Person is a person diagnosed with a serious mental or physical condition; or
 - the Covered Person has a significant behavioral problem as determined by their physician.

Treatment is subject to all terms, conditions, exclusions and benefit maximums of this Plan, including deductible, coinsurance, and co-pays.

- [13.] charges for Medically Necessary medical foods and low protein modified food products administered under the direction of a Physician for Covered Persons inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism after the Covered Person has exceeded \$2,400 worth of expenses for these food products during the Year.

- [14.] charges for treatment of loss or impairment of speech or hearing.

- [15.] charges for In-vitro fertilization procedures, including cryopreservation, for the Insured Individual and the Insured Individual's spouse, if an Insured Individual, if all the following conditions are met:

- the patient and patient's spouse have a history of unexplained infertility of at least 2 years; or the infertility is associated with one or more of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol; blockage of, or surgical removal of, one or both fallopian tubes except due to voluntary sterilization, or abnormal male factors contributing to the infertility;
- the patient's oocytes are fertilized with her spouse's sperm;
- the patient has been unable to attain a successful pregnancy through other applicable treatments for which coverage is provided under the Certificate; and
- the in-vitro fertilization procedure is performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the Department that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.

Covered Charges related to in-vitro fertilization are subject to a [15,000] lifetime maximum.

- [16.] charges for Medically Necessary cancer treatment drugs and their administration. If the drug is not approved by the United States Food and Drug Administration for use in the treatment of cancer, it will be covered if the drug is recognized as safe and effective for treatment of that specific type of cancer being treated in one of the following standard reference compendia:

- the American Hospital Formulary Service drug information,
- the National Comprehensive Cancer Network Drugs and Biologics Compendium,
- the Elsevier Gold Standard's Clinical Pharmacology, or
- Two articles from medical literature, which have not had their recognition of the drug's safety and effectiveness contradicted in clear and convincing evidence.

- [17.] charges for at least one (1) screening per year for any male Insured Individual forty (40) years of age or older according to the National Comprehensive Cancer Network guidelines. This coverage shall not be subject to Deductibles.
- [18.] charges for treatment of Mental or Nervous Disorders, including Drug Dependency, same as any other physical Medical Condition.
- [19.] Children's Preventive Health Care Services - Benefits will be paid for visits at approximately the following ages: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years. Benefits for all Children's Preventive Health Care Services, other than immunizations, will be payable at the same Deductible, Copayment and maximum amounts as apply to similar services covered under the Policy. Benefits will not exceed the level established by the Arkansas Medicaid Program for the same service or supply. Immunizations given during Children's Preventive Health Care Service visits are exempt from any Deductible or Copayment.
- [20.] [Hearing aids – The coverage provided shall not be for less than \$1400.00 per ear for each three-year period and shall not be less than \$1400.00 per ear beginning on the first day of coverage. Coverage shall not be subject to policy deductibles or copayment requirements.]
- [21.] [Treatment of bone and joints of the face, head and neck (TMJ) - Coverage shall be provided for medically necessary diagnosis and treatment, both of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage includes surgical and nonsurgical procedures. This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.]

[Physiotherapy Expenses

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

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

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

[Pregnancy Benefits

Covered Expenses for pregnancy are payable the same as any other Covered Expenses for any other Bodily Infirmary [with respect to an Insured Student or Covered Dependent spouse. No benefits are payable for any expense that relates to the pregnancy of a Dependent Child].

Pregnancy coverage also includes inpatient Hospital care following delivery in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of OB/GYNs, which is a minimum of 48 hours following a vaginal delivery or a minimum of 96 hours following a caesarean section. A decision to shorten the length of stay may be made by the attending physician in consultation with the mother.]

[Newborn Infants

A newborn Child of an Insured Student will automatically be an Insured Individual for 31 days from the moment of birth **only** for Covered Expenses incurred which are due directly to Injury or Bodily Infirmary, premature birth, or a congenital condition which exists at birth. In order to continue the coverage of a newborn Child beyond the 31st day following date of birth: (1) notice of the birth of the Child must be provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, must be received by the Company. If (1) and (2) above are not satisfied, coverage of a newborn Child, including any Continuation of Benefits, will terminate 31 days from the date of birth.]

[Newborn Infants - Well Baby Care: A newborn Child of an Insured Student will be an Insured Individual from the moment of birth if: (1) notice of the birth of the Child is provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, is received by the Company. Covered expenses for the newborn Child will include: (a) Hospital room and board (or nursery) charges, (b) routine Doctor visits while Hospital confined; and (c) circumcision while Hospital confined. Such covered expenses for Well Baby Care are payable until the earlier of the date the Child is discharged from the Hospital or the date the Child is [7] days old.]

Post-Mastectomy Coverage

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

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

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

[Intercollegiate/Interscholastic Sports Benefit

Benefits will be payable up to a maximum benefit of [\$10,000] arising out of practice for or participation in interscholastic or intercollegiate sports in any consecutive 12 month period.]

Medical Evacuation Benefit

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

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

[Repatriation Benefit

Subject to prior approval from the Company or its authorized administrator, as an additional benefit, the policy will cover up to a maximum benefit of [\$25,000] in the aggregate, reasonable expenses which are incurred in connection with the preparation and transportation of the body of a deceased Insured Individual to the individual's place of residence in the individual's home country. This benefit does not include transportation expenses of any person accompanying the body.]

Continuation Benefits

Covered expenses incurred, while hospital confined, will be payable up to a maximum benefit of [\$5,000 or 13 weeks], whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's insurance terminates. Such benefits terminate if the Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

Coordination of Benefits

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

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

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

A plan is primary when:

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

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

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

However, if the court decrees one of the parents responsible for health care expenses, the plan which covers that parent is primary. If the decree names the parent other than the natural parent with custody, the Company must be notified and have actual knowledge of those terms. Any Benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and third, respectively. If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. Continuation coverage. Continuation coverage provided under either federal or state law is secondary.
4. Length of coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary. If none of the preceding requirements determines the primary plan, the allowable expenses will be shared equally between the plans.

If this Plan is determined to be secondary, benefits payable under this Policy will be reduced so that the total benefits provided by all plans during a Claim Determination Period are not more than the total Allowable Expenses for the Insured Individual. The Company will use the amount

by which benefits have been reduced to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period and have been submitted for that person.

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

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

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

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

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

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

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;
3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. government plans, except Medicaid;
6. single or family subscribed plans issued under a group or blanket type plan;
7. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
8. individual health benefit plan; but the definition of plan shall not include:
 1. hospital indemnity type plans;
 2. school accident-type coverage;

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for medical care, treatment, supplies, or services not listed in the types of Covered Expenses;
2. for medical care, treatment, supplies or services for the Insured Individual in his/her home country or country of regular domicile;
3. for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, [abortion (except spontaneous and non-elective abortion),] circumcision [(except as covered under the Newborn Infants - Well Baby Care provision)], (Note: remove brackets if Well-Baby covered, otherwise delete text) learning disabilities, immunization, obesity, allergy tests, vitamins, and antitoxins;
4. for routine physical or health examinations, except if listed as a Covered Expense under the Medical Benefits section;
5. for any care in connection with the teeth, gums, jaw, or structures directly supporting the teeth, myofacial pain, or temporomandibular joint dysfunction, except the policy will cover Injury to natural teeth resulting from an Accident, up to a maximum benefit of [\$100] per tooth[and an overall maximum benefit of [\$500]] per Accident;
6. in excess of the Reasonable and Customary charge;

7. for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from: (a) an Injury (b) a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or (c) a mastectomy (refer to the Post Mastectomy Coverage provision);
8. for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
9. for [hearing aids,] eyeglasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery;
10. for Injury or Bodily Infirmary if covered to any extent under: any occupational benefit plan; Worker's Compensation or similar law; medical payments under individual automobile insurance (except for no-fault auto insurance);
11. [for birth control, including surgical procedures and devices;] (Note: use if oral contraceptives are not covered.)
[for birth control devices and surgical procedures;] (Note: use if oral contraceptives are covered)
12. [for Injury arising out of practice for or participation in professional sports;] [for medical care, treatment, supplies or services in excess of [\$10,000] arising out of practice for or participation in interscholastic or intercollegiate sports in any consecutive 12 month period;]
- [13.] for medical care, treatment, services, and supplies for which no charge is made or for which no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
- [14.] for intentionally self-inflicted Injury or Bodily Infirmary, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmary resulting from taking part in the commission of an assault or felony;
- [15.] for diagnosis, treatment and all other care related to infertility;
- [16] for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
- [17.] Transcutaneous Electrical nerve Stimulation (TENS) units.
- [18.] for Injury or Bodily Infirmary from a Mental or Nervous Disorder, alcoholism or drug dependency; except that benefits will be paid for treatment up to (a) an aggregate limit of [30] [10] days of inpatient care in any consecutive 12-month period payable at [100%] after the [Deductible] [Copayment] with respect to a mental or nervous disorder or drug dependency, and (b) outpatient treatment up to a benefit limit of [10] [3] outpatient visits in any consecutive 12 month period, payable at [100%] after the Deductible] [Copayment] with respect to a mental or nervous disorder, alcoholism, or drug dependency;
- [19]. resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license [in the state where the Insured Individual primarily resides while attending school];
- [20]. for Injury or Bodily Infirmary resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
- [21.] for medical care, treatment, services, or supplies normally given without charge and provided by employees or Physicians employed by, under contract with, or retained by the Policyholder unless provided in a Student Health Center by its employees; and
- [22.] for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy.
- [23.] for the treatment of sex transformation surgery and related services, or the reversal thereof;
- [24.] for medication prescribed as a smoking deterrent;
- [25.] for the treatment of Alopecia (loss of hair);
- [26.] for the treatment of Acne;
- [27.] for Anorectics (any drug used for the purpose of weight control);
- [28] for medical and surgical treatment of excessive sweating (Hyperhidrosis);
- [29.] for the treatment of benign Gynecomastia (abnormal breast enlargement in males);
- [30.] for the treatment (including cutting or removing) of toe nails or superficial lesions of the feet including corns, calluses and Heperkeratoses, other than removal of nail matrix or root.

[31.] for treatment of any Injury or Bodily Infirmary sustained while the Insured Individual is under the influence of illegal narcotics or a non-prescribed controlled substance, including alcohol.

Pre-Existing Condition Limitations

The policy will not cover charges or expenses due to a pre-existing Injury or Bodily Infirmary or complication thereof. A pre-existing Injury or Bodily Infirmary is one where the Insured Individual has consulted a Physician; had medicine prescribed; or is receiving or has received medical care for that Injury or Bodily Infirmary in the 6 months prior to the Insured Individual's Effective Date of Coverage under the Policy.

However, after an Insured Individual's insurance has been in force for 12 consecutive months, Covered Expenses incurred after this 12 month period for a pre-existing Injury or Bodily Infirmary will be payable.

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

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

"Creditable Coverage" means any of the following coverage, obtained in the United States an Insured Individual had prior to enrollment under the Policy: an employee group health plan; health insurance coverage, individual or group, including coverage through a Health Maintenance Organization (HMO); Medicare; Medicaid; TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families; a medical care program of the Indian Health Service or of a tribal organization; a state health risk pool; a health plan offered under the Federal Employee Health Benefits Program; a public health plan established or maintained by a political subdivision of a state to provide insurance coverage; a health benefit plan established by the Peace Corps Act; or a State Children's Health Insurance Program (S-CHIP).

Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under this Policy to group coverage by another plan. Coverage provided by this Policy is not considered Creditable Coverage by this or other student health policies.

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

"Federally Eligible Individual" means an individual who meets all of the following: the individual has at least 18 months of Creditable Coverage as of the date on which the individual seeks coverage under this Policy; the individual's most recent prior Creditable Coverage was under one of the following types of plans or an insurance plan offered in connection with an employee group health plan, governmental plan or church plan; the individual is not eligible for coverage under a group health plan, Medicare or Medicaid; the individual does not have other health insurance coverage; the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and if the individual has the option to continue coverage under a COBRA continuation or similar State program, such coverage was elected and exhausted.

DEFINITIONS

"**Accident**" means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual and independent of any other such force or event.

“Average Semiprivate Charge” means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

“Bodily Infirmary” means a Medical Condition of an Insured Individual caused by, arising out of, resulting from or the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual.

“Close Relative” means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.

“Copayment” means that portion of a Covered Expense an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion].

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

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

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

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

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

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

“Hospital” means only such a place which is lawfully operated and licensed as a hospital for the care and treatment of sick or injured individuals; has permanent and full-time care for bed patients; has a staff of one or more licensed physicians available at all times; provides 24-hour a day care by registered nurses on duty or call; has surgical facilities; and is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a hospital used as such. Hospital also means a free standing surgical center which: is a licensed public or private place; has an organized medical staff of Physicians; has permanent facilities that are equipped and operated mainly for performing surgery and giving skilled nursing care; and has RN services in the facility.

“Hospital Admission” means a single period of hospital confinement or outpatient care for one or more causes.

“Injury” means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a sudden, and unforeseen force or event external to that Insured Individual.

"Insured Individual" means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements

"Insured Student" means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.

"Intensive Care Unit" means a unit exclusively reserved for critically and seriously sick or injured patients requiring constant audio-visual observation, as prescribed by the attending Doctor, which provides room and board, trained and qualified personnel whose duties are primarily confined to such unit, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the Hospital's facilities.

“Medical Condition” means any bodily or mental disease, illness or injury requiring treatment by a Physician.

"Medically Necessary (Medical Necessity)" means a service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis Or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

- is Experimental, investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient's family, Physician, hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration[except as permitted by regulations drafted in accordance with applicable federal law]; or
- involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare and Medicaid National Coverage Determinations Manual.
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We retain the right to determine whether a service, supply, or drug is Medically Necessary.

“Mental or Nervous Disorder” means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder.

“Participating Provider” means a Doctor or a Hospital that agrees to provide Medically Necessary care and treatment at set rates.

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

“Placed For Adoption” means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of adoption. Placement is considered terminated upon termination of legal obligation.

"Policy" means the Policy including all amendments, riders, endorsements and applications.

"**Policyholder**" means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.

"**Reasonable and Customary**" means, with regard to charges for medical services or supplies, the lowest of:

1. the usual charge by the provider for the same or similar medical services or supplies;
2. the usual charges of most providers of similar training and experience in the same or similar geographic 'area' for the same or similar service or supplies; or
3. the actual charge for the services or supplies.

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

"**Sickness**" means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from or the cause of One Period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. "One Period" commences with the onset of the initial (or only) Bodily Infirmary that occurred during the Sickness, and ends when the Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmary that occurred during that Sickness for ninety (90) consecutive days.

["**Student Health Center**" means an ambulatory care facility affiliated or contracted with the Policyholder that at a minimum maintains a staff consisting of a nurse director/nurse practitioner, staff nurses and a staff physician or an arrangement with a physician to perform office visits. [(s Student Health Center also includes a designated walk-in pharmacy clinic or other similar facility specified by the educational institution if such institution does not have a designated Student Health Center)]]].

DENTAL CARE BENEFITS

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

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

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

DEDUCTIBLE

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

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

INSURING CLAUSE

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

1. the Deductible requirement, if any, is met;

2. the expense is incurred while insured for this coverage;
3. the Insured Individual has not exceeded the Policy's Dental Care Benefits maximum.

COVERED DENTAL CARE EXPENSE

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

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

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

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

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

[[2.] Basic Dental Care that means care and supplies for fillings (amalgams).

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

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

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

DENTAL CARE EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for Dental care or supplies which are not included under Covered Dental Care Expense;
- [2] for Dental care or supplies furnished outside the United States;]
- [3.] in excess of Reasonable and Customary charge;
- [4.] for Injury resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;

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

DEFINITIONS - Dental Care Benefits

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

1. "**Close Relative**" means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.
2. "**Dentist**" means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.
3. "**Injury**" means an accidental dental injury sustained by an Insured Individual which results directly from an accident which occurs independent of any and all other causes.
4. "**Insured Individual**": means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements.
5. "**Insured Student**" means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
6. "**Medically Necessary (Medical Necessity)**: A service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

- is Experimental, investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient's family, Physician, hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration[except as permitted by regulations drafted in accordance with applicable federal law]; or
- involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare and Medicaid National Coverage Determinations Manual.

We retain the right to determine whether a service, supply, or drug is Medically Necessary.

7. "**Policy**" means the Policy including all amendments, riders, endorsements, and applications.

8. "**Policyholder**" means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.

9. "**Sickness**" means a dental infirmity of an Insured Individual that is the sole cause of loss.

10. "**Reasonable and Customary**" means, with regard to charges for dental services or supplies, the lowest of:

- a. the usual charge by the provider for the same or similar dental services or supplies;
- b. the usual charges of most providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies; or
- c. the actual charge for the services or supplies.

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

[OPTIONAL STUDENT ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)]

Student Only Coverage

[Maximum Amount of Insurance **[\$5,000]**

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

Reduction Schedule - Coverage terminates at age 65

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

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

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

[Life	The maximum]
[A hand by severance through or above the wrist	1/2 the maximum]
[A foot by severance through or above the ankle	1/2 the maximum]
[Irrecoverable loss of sight of one eye	1/2 the maximum]]
[Speech or hearing	1/2 the maximum]]
[Quadriplegia*]	[The maximum]
[Paraplegia or Hemiplegia*]	[1/2 the maximum]
[Thumb and index finger of same hand]	[1/4 of the maximum]
[Both hands or both feet	The maximum]
[Sight of both eyes	The maximum]
[Combination of two: hand, foot or sight	The maximum]
[Speech and hearing	The maximum]
[One hand, one foot or sight of one eye	1/2 the maximum]
[Two or more Members**]	[The maximum]
[Irrecoverable loss of speech and hearing (both ears)]	[The maximum]
[One Member**]	[1/2 the maximum]
[Irrecoverable loss of speech or hearing (both ears)]	[1/2 the maximum]

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

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

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

EXCEPTIONS AND EXCLUSIONS

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

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

BENEFICIARY

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

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

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

If the Company pays the Benefit before receiving the notice of a change in Beneficiary, the Company does not have to pay the Benefit again. If the Insured Student's Beneficiary dies before the Insured Student does, the Company will pay the Benefit to any remaining Beneficiaries. [When this plan replaces a Group Policy the Company previously issued (and under which the Insured Student was previously covered) the Insured Student's named Beneficiary and his/her elected settlement option will remain the same unless changed by the Insured Student as shown above.]

DEFINITIONS - Accidental Death and Dismemberment

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

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

Prescription Drug Card

The prescription drug card program is offered through [Express Scripts], and provides coverage for many prescription drugs. The program is available at participating pharmacies nationwide.

The list of drugs included on the plan generally matches the type of drugs covered by the LowerMark inbound programs. Participating pharmacies can be located by visiting Express Scripts website: www.member.express-scripts.com and creating a member account using the ID number located on the insured's [Express Scripts] ID Card. You can also get pharmacy information by contacting Express Scripts at [1-800-451-6245].

The prescription drug card does not guarantee that a prescription will be covered. For prescription reimbursements, please complete a claim form and mail to the Lower Agency for reimbursement. Mail completed form to:

The Lower Agency, Inc.
P.O. Box 32247
Kansas City, MO 64171-5247

24/7 NURSE LINE

This service provides the student with 24 hour telephone access to a care specialist and nurses. Nurses can provide the student with easy to understand information on a wide range of health

issues. The toll free number is [866-549-5076]. Students can access the Nurse Line 24 hours a day, 7 days a week.

Global Emergency Medical Evacuation – [Assist America]

In the event that an Insured Individual becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transportation necessary to evacuate an Insured Individual to the nearest facility capable of providing appropriate care. With one phone call, Assist America's team of professionals will handle the transportation arrangements to a more suitable hospital.

[Assist America's] medical personnel will also maintain regular communication with the Insured Individual's attending physician and/or hospital and relay any information to the Insured Individual's family.

For global emergency assistance call [Assist America's] toll free number, [800-872-1414], or if outside of the United States call collect at [609-452-8570].

Repatriation – [Assist America]

If an Insured Individual requires medical assistance upon being discharged from a hospital, Assist America will repatriate him/her home or to a rehabilitation facility with a medical or non-medical escort, as necessary. In the event of death of an Insured Individual, Assist America will render every possible assistance in returning the mortal remains including locating a funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport. An Assist America card will be supplied to the Insured Individual once the student has enrolled in the LewerMark health insurance plan.

The [Assist America] card must be carried at all times. For global emergency assistance or when the Insured Individual is 100 miles away from his/her primary residence a toll-free number is available, [800-872-1414], or if outside of the United States call collect at [609-452-8570].

Finding a PPO Network Provider – [PHCS]

By enrolling in this insurance program the insured member has the [PHCS] Provider Network available for in-network medical services. The use of a provider in the [PHCS] network may reduce the insured's out of pocket expenses, as network providers have negotiated to accept lower fees as payment for their services.

There are many doctors and hospitals available. Go to www.LewerMark.com and click "Find a Doctor." Select [Private Health Care Systems] as the PPO network.

CLAIMS PROCEDURE

Written notice of any event that may lead to a claim under the policy must be given to the Company or its authorized administrator within 60 days after the event, or as soon thereafter as reasonably possible. When the Company receives notice of the claim, We will send claim forms for filing.

Written proof of loss must be furnished to the Company within 90 days after the date of loss or as soon thereafter as reasonably possible. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss.

Claim Payment

Benefits will be paid as soon as the company received satisfactory proof of loss. All benefits [(other than for accidental loss of life)] will be paid to the Insured Student subject to any written assignment of benefits by the Student which is authorized by the Policy and made on a form satisfactory to the Company [If the Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.]

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

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

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

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

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

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

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

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

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

HIPAA

HIPAA Privacy: The Lewer Agency, Inc. and Trustmark Life Insurance Company value your privacy and have in place policies to protect your private health information. To view both of our HIPAA Privacy Policies, please see our website at www.LewerMark.com. A copy of the Trustmark Life Insurance Company policy notice is attached at the back of this Certificate. To obtain a copy of the Lewer policy, please contact The Lewer Agency, Inc., Privacy Officer, [4534 Wornall Road, Kansas City, Missouri, 64111, (816) 753-4390 or (800) 821-7715].

IMPORTANT NOTICE

This is only a summary of a master insurance policy (the Master Policy) issued to the Policyholder by the Company. The Master Policy contains language and provisions not contained in this brochure. In the event of a conflict between this brochure and the Master Policy, the Master Policy will govern.

Any provision of the Master Policy in conflict with the laws of the jurisdiction in which the Policyholder is located is hereby automatically amended to conform to the minimum requirement of those laws.

The Policyholder requires its international and practical training students to carry medical insurance coverage. This coverage must be accepted by the student unless proof of other coverage (acceptable to the Company) is provided.

For information and assistance, call the Lewer Agency at 1-800-821-7710.

**Insured By:
Trustmark Life Insurance Company**

LEWERMARK

Medical Benefits Plan for Outbound Students

COVERAGE FOR OUTBOUND DOMESTIC STUDENTS THAT EVERYONE CAN UNDERSTAND

Making a World of Difference

Benefits for Accident and Sickness, exclusively for [Name of School]

- **[\$50]** Plan Deductible per cause
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Kansas City, Missouri 64171-5247
Phone 1/800-821-7710 Fax 1/816-960-7064
www.LewerMark.com

Insured By:
Trustmark Life Insurance Company

ELIGIBILITY

The LowerMark outbound domestic students Medical Benefits Plan is designed for outbound students and other persons of similar description and their dependents. The Plan is available by virtue of a master blanket insurance policy issued by the Company, Trustmark Life Insurance Company, to a university, college or other educational organization (the "Policyholder").

Eligible Student: An "Eligible Student" means any practical [training], outbound domestic student [and] [visiting faculty][scholar] [or] [exchange visitor] of the Policyholder who is engaged full-time in educational activities, is temporarily outside his/her home country or country of regular domicile as a non-resident alien; and has a current passport or applicable student visa. To be an Insured Individual under the Policy, the student must have paid the required premium. The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, it's only obligation is to refund premium less any claims paid.

"Eligible Dependent" An "Eligible Dependent" means a dependent of an Eligible Student who has a current passport or visa; is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien, is the Eligible Student's lawful spouse or unmarried child (natural child, step-child, adopted child or Child Placed For Adoption under age [19] and dependent upon the Eligible Student or the student's spouse for the child's main support and care); resides with the Eligible Student; and is enrolled for coverage under the policy at the same time the Eligible Student enrolls or within 31 days of first becoming eligible. Dependent children born in the United States are also Eligible Dependents. A disabled, unmarried Child of an Insured Student is also an Eligible Dependent if all the following conditions are met:

1. The Child became disabled before reaching age [19];
2. The Child is incapable of self-sustaining employment because of a developmental disability or physical handicap and is chiefly dependent upon the Insured Student for support and maintenance;
3. The student remains insured under the Policy;
4. The Child's premium, if any, continue to be paid;
5. The Insured Student furnishes to the Company, a statement of disability. The Company's approval of such statement is required for the Child to continue eligibility; and
6. The Insured Student provides proof satisfactory to the Company of the Child's disability and dependent status when requested by the Company. Such proof shall be without cost to the Company. The Company will not ask for proof more often than once a year after the two-year period following the Child's attainment of age [19].]

[Extended Coverage applies to Eligible Dependents of newly enrolled students who arrive in the country in which the student is attending school prior to the commencement of their studies.]

[A student covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:

1. the request is made prior to the termination of extended coverage;
2. premium is promptly paid for the additional 30 days of coverage; and
3. the Insured Student and covered dependents, if any, remain in the country in which the individual is attending school.]

[Coverage for an Eligible Dependent of an Eligible Student will be effective 30 days prior to the date of any school term start date.]

EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Provided an Enrollment is properly completed and the correct premium is received timely, an Eligible Student becomes an Insured Individual:

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

[Extended Coverage applies to newly enrolled students who arrive in the country in which the student is attending school prior to the commencement of their studies.] [Coverage for an Eligible Student under Extended Coverage will be effective 30 days prior to the date of any school term start date.] [Coverage for an Insured Individual under Extended Coverage will terminate 30 days following graduation or completion of an educational program provided the Insured Individual remains in the country in which such individual is attending school.]

[A student covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:

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

[For Eligible Dependents:

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

1. the date the Eligible Student's coverage begins with respect to each Eligible Dependent the student has at time of his/her enrollment;
2. the date of birth, if enrollment is made within 90 days of such event or by the next premium date, whichever is greater;
3. for adopted children, from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after birth;
4. on the first day of the first month following the dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured Student is covered under the Policy;
5. on the first day an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
6. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Dependent or after an Eligible Dependent suffers an involuntary loss of other coverage; or
7. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

Dependent coverage cannot become effective prior to the effective date of coverage of the Eligible Student.

TERMINATION OF INDIVIDUAL COVERAGE

Coverage for an insured individual will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
2. The last day of the period for which premium has been timely paid according to Policy provisions;
3. The date the Insured Individual is no longer eligible for coverage;
4. The date requested by the Insured Individual approved by the Policyholder in writing that is no sooner than 5 days after the date the Company (or its authorized administrator) receives written notice;
5. The date the Insured Individual departs for the Student's home country or country of regular domicile.

See the Effective Date For Individual Coverage provisions for a comprehensive description of Extended Coverage.

To avoid a break in coverage, (and another pre-existing condition limitation period), students should make sure coverage is in place and paid for when taking a term off from school, even if the student is leaving the country. Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from this Policy to group coverage provided under another plan.

MEDICAL EXPENSE BENEFITS

Each Insured Individual has a Major Medical Benefit maximum of [\$50,000] per Accident or Sickness, but not exceeding [\$50,000] for all Accidents and Sickness in any consecutive 12 month period.

Deductibles

The Deductible is the amount of Covered Expenses the Insured Individual must pay per Accident or Sickness before Benefits are paid. Benefits will be paid at [100%] after satisfying the following Deductible amounts:

1. With respect to the Insured Student there will be a [\$100] Deductible per Accident or Sickness.
2. With respect to the Insured Individual who is the Eligible Dependent, there will be a [\$100] Deductible per Accident or Sickness.
3. With respect to any Insured Individual, there will be an additional [\$50] Deductible per Sickness before a benefit is payable for Covered Expenses which are incurred for visits to a Hospital emergency room. Such Deductible shall not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.

Benefits will be paid at the levels described above unless stated otherwise.

INSURING CLAUSE

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

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

Medical Benefits

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable as stated above for a Covered Expense if: (1) the Deductible requirement is met; (2) the expense is incurred due to a covered Injury or Bodily Infirmary; and (3) the Insured Individual has not exceeded the Major Medical Benefit maximum for the Accident or Sickness for which the expense

is incurred, or for all Accidents or Sickness in any consecutive 12 month period. Covered Expenses under the Policy are limited to the following types of expenses prescribed by a Physician for therapeutic treatment of covered Injury or Bodily Infirmary when the fees for such are Reasonable and Customary:

1. Charges for diagnosis and treatment by a Physician or registered nurse (not a close relative of or same legal residence as the Insured Individual);
2. Charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges;
3. Charges by a Hospital for medical care received on an outpatient basis and outpatient medical supplies used on the premises of a Hospital;
4. Charges for laboratory, x-ray, and other diagnostic examinations;
5. Charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay [100%] of charges for such drugs used on an inpatient basis and [50%] of charges for such drugs used for outpatient treatment;
6. Charges for emergency professional ambulance service by ground or air to a Hospital up to a maximum benefit of \$500 (see Medical Evacuation Benefit for air service to an Insured Individual's home country);
7. Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
 - (a) man-made limbs or eyes for the replacing of natural limbs or eyes;
 - (b) casts, splints or crutches;
 - (c) purchase of a truss or brace;
 - (d) oxygen and rental of equipment for giving oxygen;
 - (e) rental of a wheelchair or hospital bed;
 - (f) rental of dialysis equipment and supplies;
 - (g) colostomy bags and ureterostomy bags; and
 - (h) two external post-operative breast prostheses.The policy will not cover rental charges for equipment in excess of the purchase price of the equipment;
8. Charges for home health care performed by a licensed home health agency when prescribed by a Physician in lieu of Hospital services, provided the Hospital services would have been Covered Expenses; and
9. Charges for one routine baseline or screening mammogram in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation;
10. Charges for one routine pap smear in any consecutive 12-month period for women age [18] and over or more frequently based on a Doctor's recommendation;]
11. Charges for prescription oral contraceptives dispensed by a Student Health Center or a licensed pharmacist; the Policy will pay up to [50%];]

- [12.] hospital or ambulatory surgical center facility charges and anesthesia charges for dental procedures provided to a Covered Person if the treating provider has certified that because of the patient's age, condition or problem, such hospitalization and general anesthesia is required to provide safe and effective treatment; and
- a Dependent under seven (7) years of age if two (2) dentists licensed in the state have determined the Dependent requires, without delay, necessary treatment for a significantly complex dental condition; or
 - The Covered Person is a person diagnosed with a serious mental or physical condition; or
 - the Covered Person has a significant behavioral problem as determined by their physician.

Treatment is subject to all terms, conditions, exclusions and benefit maximums of this Plan, including deductible, coinsurance, and co-pays.

- [13.] charges for Medically Necessary medical foods and low protein modified food products administered under the direction of a Physician for Covered Persons inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism after the Covered Person has exceeded \$2,400 worth of expenses for these food products during the Year.

- [14.] charges for treatment of loss or impairment of speech or hearing.
- [15.] charges for In-vitro fertilization procedures, including cryopreservation, for the Insured Individual and the Insured Individual's spouse, if an Insured Individual, if all the following conditions are met:
- the patient and patient's spouse have a history of unexplained infertility of at least 2 years; or the infertility is associated with one or more of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol; blockage of, or surgical removal of, one or both fallopian tubes except due to voluntary sterilization, or abnormal male factors contributing to the infertility;
 - the patient's oocytes are fertilized with her spouse's sperm;
 - the patient has been unable to attain a successful pregnancy through other applicable treatments for which coverage is provided under the Certificate; and
 - the in-vitro fertilization procedure is performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the Department that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.
- Covered Charges related to in-vitro fertilization are subject to a [15,000] lifetime maximum.
- [16.] charges for Medically Necessary cancer treatment drugs and their administration. If the drug is not approved by the United States Food and Drug Administration for use in the treatment of cancer, it will be covered if the drug is recognized as safe and effective for treatment of that specific type of cancer being treated in one of the following standard reference compendia:
- the American Hospital Formulary Service drug information,
 - the National Comprehensive Cancer Network Drugs and Biologics Compendium,
 - the Elsevier Gold Standard's Clinical Pharmacology, or
 - Two articles from medical literature, which have not had their recognition of the drug's safety and effectiveness contradicted in clear and convincing evidence.
- [17.] charges for at least one (1) screening per year for any male Insured Individual forty (40) years of age or older according to the National Comprehensive Cancer Network guidelines. This coverage shall not be subject to Deductibles.
- [18.] charges for treatment of Mental or Nervous Disorders, including Drug Dependency, same as any other physical Medical Condition.
- [19.] Children's Preventive Health Care Services - Benefits will be paid for visits at approximately the following ages: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years. Benefits for all Children's Preventive Health Care Services, other than immunizations, will be payable at the same Deductible, Copayment and maximum amounts as apply to similar services covered under the Policy. Benefits will not exceed the level established by the Arkansas Medicaid Program for the same service or supply. Immunizations given during Children's Preventive Health Care Service visits are exempt from any Deductible or Copayment.
- [20.] [Hearing aids – The coverage provided shall not be for less than \$1400.00 per ear for each three-year period and shall not be less than \$1400.00 per ear beginning on the first day of coverage. Coverage shall not be subject to policy deductibles or copayment requirements.]
- [21.] [Treatment of bone and joints of the face, head and neck (TMJ) - Coverage shall be provided for medically necessary diagnosis and treatment , both of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage includes surgical and nonsurgical procedures. This coverage shall be the same as that

provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.]

[Physiotherapy Expenses

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

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

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

Pregnancy Benefits

Pregnancy coverage also includes inpatient Hospital care following delivery in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of OB/GYNs.

[Newborn Infants

A newborn Child of an Insured Student will automatically be an Insured Individual for 31 days from the moment of birth **only** for Covered Expenses incurred which are due directly to Injury or Bodily Infirmary, premature birth, or a congenital condition which exists at birth. In order to continue the coverage of a newborn Child beyond the 31st day following date of birth: (1) notice of the birth of the Child must be provided to the Company within 90 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, must be received by the Company. If (1) and (2) above are not satisfied, coverage of a newborn Child, including any Continuation of Benefits, will terminate 31 days from the date of birth.]

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

Post-Mastectomy Coverage

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

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

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

Intercollegiate/Interscholastic Sports Benefit

Benefits will be payable up to a maximum benefit of [\$10,000] arising out of practice for or participation in interscholastic or intercollegiate sports in any consecutive 12 month period.

Medical Evacuation Benefit

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

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

[Repatriation Benefit

Subject to prior approval from the Company or its authorized administrator, as an additional benefit, the policy will cover up to a maximum benefit of **[\$25,000]** in the aggregate, reasonable expenses which are incurred in connection with the preparation and transportation of the body of a deceased Insured Individual to the individual's place of residence within the United States where the Insured Individual is to be buried. This benefit does not include transportation expenses of any person accompanying the body.]

Continuation Benefits

Covered expenses incurred, while hospital confined, will be payable up to a maximum benefit of **[\$5,000 or 13 weeks]**, whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's insurance terminates. Such benefits terminate if the Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

Coordination of Benefits

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

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

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

A plan is primary when:

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

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

1. Insured Student: The plan which covers the person as an Insured Student is primary. If an Insured Individual is also covered by Medicare, the plan covering the person as an Insured Student is primary, the plan covering the person as a dependent of an Insured Student is secondary, and then Medicare.
2. Dependent Children:
 - a. If the parents are not separated or divorced, the plan which covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan which covered the parent longer is primary. If

the other plan does not follow the "birthday rule", the other plan is primary.

- b. If the parents are separated or divorced, the plan which covers the natural parent with custody is primary; followed by the plan which covers the step-parent who has married the natural parent with custody; the plan which covers the natural parent without custody, and finally, the plan of the spouse of the natural parent without custody.

However, if the court decrees one of the parents responsible for health care expenses, the plan which covers that parent is primary. If the decree names the parent other than the natural parent with custody, the Company must be notified and have actual knowledge of those terms. Any Benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and third, respectively. If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. Continuation coverage. Continuation coverage provided under either federal or state law is secondary.

4. Length of coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary.

If none of the preceding requirements determines the primary plan, the allowable expenses will be shared equally between the plans.

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

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

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

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

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

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

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

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;

3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. government plans, except Medicaid;
6. single or family subscribed plans issued under a group or blanket type plan;
7. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
8. individual health benefit plan; but the definition of plan shall not include:
 1. hospital indemnity type plans;
 2. school accident-type coverage;

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

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

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

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

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

4. for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, [abortion (except spontaneous and non-elective abortion)], circumcision, [(except as covered under the Newborn Infants - Well Baby Care provision)], (Note: remove brackets if Well-Baby covered, otherwise delete text) learning disabilities, immunization, obesity, allergy tests, vitamins, and antitoxins;
5. for routine physical or health examinations, except if listed as a Covered Expense under the Medical Benefits section;
5. for any care in connection with the teeth, gums, jaw (except due to Injury resulting from an Accident), or structures directly supporting the teeth, myofacial pain, or temporomandibular joint dysfunction, except the policy will cover Injury to natural teeth resulting from an Accident, up to a maximum benefit of [\$100] per tooth[and an overall maximum benefit of [\$500]] per Accident;
6. in excess of the Reasonable and Customary charge;
7. for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from: (a) an Injury; (b) a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or (c) a mastectomy (refer to the Post Mastectomy Coverage provision);

8. for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
9. for [hearing aids,] eyeglasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery;
10. for Injury or Bodily Infirmity if covered to any extent under any occupational benefit plan, Workers Compensation or similar law or medical payments under individual automobile insurance (except no-fault);
11. [for birth control, including surgical procedures and devices;] (Note: use if oral contraceptives are not covered.)
[for birth control devices and surgical procedures;] (Note: use if oral contraceptives are covered)
12. [for Injury arising out of practice for or participation in professional sports;] [for medical care, treatment, supplies or services in excess of [\$10,000] arising out of practice for or participation in interscholastic or intercollegiate sports in any consecutive 12 month period;]
13. for medical care, treatment, services, and supplies for which no charge is made or for which no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
14. for intentionally self-inflicted Injury or Bodily Infirmity, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmity resulting from taking part in the commission of an assault or felony;
15. for diagnosis, treatment and all other care related to infertility;
16. for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
- [17.] Transcutaneous Electrical nerve Stimulation (TENS) units
- [18.] for Injury or Bodily Infirmity from a Mental or Nervous Disorder, alcoholism or drug dependency; except that benefits will be paid for treatment up to (a) an aggregate limit of [30] [10] days of inpatient care in any consecutive 12-month period payable at 100%] after the [Deductible] with respect to a mental or nervous disorder or drug dependency, and (b) outpatient treatment up to a benefit limit of [10] [3] outpatient visits in any consecutive 12 month period, payable at [100%] after the [Deductible] with respect to a mental or nervous disorder, alcoholism, or drug dependency;
17. resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license;
18. for Injury or Bodily Infirmity resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
19. for medical care, treatment, services, or supplies normally given without charge and provided by employees or Physicians employed by, under contract with, or retained by the Policyholder; and
20. for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy.
- [21.] for the treatment of sex transformation surgery and related services, or the reversal thereof;
- [22.] for medication prescribed as a smoking deterrent;
- [23.] for the treatment of Alopecia (loss of hair);
- [24.] for the treatment of Acne;
- [25.] for Anorectics (any drug used for the purpose of weight control);
- [26.] for medical and surgical treatment of excessive sweating (Hyperhidrosis);
- [27.] for the treatment of benign Gynecomastia (abnormal breast enlargement in males);
- [28.] for the treatment (including cutting or removing) of toe nails or superficial lesions of the feet including corns, calluses and Heperkeratoses, other than removal of nail matrix or root.
- [29.] for treatment of any Injury or Bodily Infirmity sustained while the Insured Individual is under the influence of illegal narcotics or a non-prescribed controlled substance, including alcohol.

Pre-Existing Condition Limitations

The policy will not cover charges or expenses due to a pre-existing Injury or Bodily Infirmity or complication thereof. A pre-existing Injury or Bodily Infirmity is one where the Insured Individual has consulted a Physician; had medicine prescribed; or is receiving or has received medical care

for that Injury or Bodily Infirmary in the 6 months prior to the Insured Individual's Effective Date of Coverage under the Policy.

However, after an Insured Individual's insurance has been in force for 12 consecutive months, Covered Expenses incurred after this 12 month period for a pre-existing Injury or Bodily Infirmary will be payable.

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

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

"Creditable Coverage" means any of the following coverage, obtained in the United States, an Insured Individual had prior to enrollment under the Policy: an employee group health plan; health insurance coverage, individual or group, including coverage through a Health Maintenance Organization (HMO); Medicare; Medicaid; TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families; a medical care program of the Indian Health Service or of a tribal organization; a state health risk pool; a health plan offered under the Federal Employee Health Benefits Program; a public health plan established or maintained by a political subdivision of a state to provide insurance coverage; a health benefit plan established by the Peace Corps Act; or a State Children's Health Insurance Plan (S-CHIP). Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under this Policy to group coverage by another plan.

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

"Federally Eligible Individual" means an individual who meets all of the following:

the individual has at least 18 months of Creditable Coverage as of the date on which the individual seeks coverage under this Policy; the individual's most recent prior Creditable Coverage was under an insurance plan offered in connection with an employee group health plan, governmental plan or church plan; the individual is not eligible for coverage under a group health plan, Medicare or Medicaid; the individual does not have other health insurance coverage; the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and if the individual has the option to continue coverage under a COBRA continuation or similar State program, such coverage was elected and exhausted.

DEFINITIONS

"Accident" means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a sudden and unforeseen force or event external to that Insured Individual and independent of any other such force or event.

"Average Semiprivate Charge" means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

"Bodily Infirmary" means a Medical Condition of an Insured Individual caused by, arising out of, resulting from or the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual

"Close Relative" means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.

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

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

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

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

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

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

"Hospital" means only such a place which is lawfully operated and licensed as a hospital for the care and treatment of sick or injured individuals; has permanent and full-time care for bed patients; has a staff of one or more licensed physicians available at all times; provides 24-hour a day care by registered nurses on duty or call; has surgical facilities; and is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a hospital used as such. Hospital also means a free standing surgical center which: is a licensed public or private place; has an organized medical staff of Physicians; has permanent facilities that are equipped and operated mainly for performing surgery and giving skilled nursing care; and has RN services in the facility.

"Hospital Admission" means a single period of hospital confinement or outpatient care for one or more causes.

"Injury" means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a sudden, and unforeseen force to that Insured Individual.

"Insured Individual" means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements

"Insured Student" means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.

"Intensive Care Unit" means a unit exclusively reserved for critically and seriously sick or injured patients requiring constant audio-visual observation, as prescribed by the attending Doctor, which provides room and board, trained and qualified personnel whose duties are primarily confined to such unit, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the Hospital's facilities.

“Medical Condition” means any bodily or mental disease, illness or injury requiring treatment by a Physician.

"Medically Necessary (Medical Necessity) means a service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

- is Experimental, investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient’s family, Physician, hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- could have been omitted without adversely affecting the person’s condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration[except as permitted by regulations drafted in accordance with applicable federal law]; or
- involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare and Medicaid National Coverage Determinations Manual.

We retain the right to determine whether a service, supply, or drug is Medically Necessary.

“Mental or Nervous Disorder” means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder.

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

“Placed For Adoption” means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of adoption. Placement is considered terminated upon termination of legal obligation.

"Policy" means the Policy including all amendments, riders, endorsements and applications.

"Policyholder" means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.

“Reasonable and Customary” means, with regard to charges for medical services or supplies, the lowest of:

- a. the usual charge by the provider for the same or similar medical services or supplies;
- b. the usual charges of most providers of similar training and experience in the same or similar geographic ‘area’ for the same or similar service or supplies; or
- c. the actual charge for the services or supplies.

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

“Sickness” means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from or the cause of One Period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. “One Period” commences with the onset of the initial (or only) Bodily Infirmary that occurred during the Sickness, and ends when the

Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmary that occurred during that Sickness for ninety (90) consecutive days.

[DENTAL CARE BENEFITS]

IMPORTANT NOTICE: The DENTAL CARE BENEFITS only apply to the Policy if it is so specified in the POLICY SCHEDULE or otherwise added by Amendment.

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

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

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

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

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

INSURING CLAUSE

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

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

COVERED DENTAL CARE EXPENSE

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

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

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

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

- [1. Preventive and Diagnostic Care that means:

- a. initial oral examination;
- b. clinical oral exams, but not more than [one] in [six] consecutive months;
- c. emergency oral exam;
- d. x-ray exams:
 - i. panorex film, but not more than [one] in [36] consecutive months;
 - ii. full mouth x-ray, but not more than [one] in [36] consecutive months;
 - iii. individual periapical x-rays; and
 - iv. bitewing x-rays; but not more than [one] in [six] consecutive months;
- e. dental prophylaxis, but not more than [one] in [six] consecutive months;
- f. topical application of fluoride for an eligible Child, but not more than [one] in [six] consecutive months.]

[[2.] Basic Dental Care that means care and supplies for fillings (amalgams).

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

[[3.] Oral Surgery that means care and supplies for:

- a. extractions of erupted and unerupted (impacted) teeth;
- b. crowns;
- c. root canals therapy (endodontic care).

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

DEFINITIONS - Dental Care Benefits

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

1. "**Close Relative**" means the student, student's spouse, and the Children, brothers, sisters and parents of either the student or student's spouse.
2. "**Dentist**" means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.
3. "**Injury**" means an accidental dental injury sustained by an Insured Individual which results directly from an accident which occurs independent of any and all other causes.
4. "**Insured Individual**": means an Eligible Student of the Policyholder and any of the student's Eligible Dependents, as described in the Eligibility Section of the Policy, for whom premium is paid and who is enrolled for coverage in accordance with Policy requirements.
5. "**Insured Student**" means an Insured Individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
6. "**Medically Necessary (Medical Necessity)**: A service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

- is Experimental, investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient's family, Physician, hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;

- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration[except as permitted by regulations drafted in accordance with applicable federal law]; or
- involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare and Medicaid National Coverage Determinations Manual.

We retain the right to determine whether a service, supply, or drug is Medically Necessary.

7. "**Policy**" means the Policy including all amendments, riders, endorsements, and applications.
8. "**Policyholder**" means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.
9. "**Sickness**" means a dental infirmity of an Insured Individual that is the sole cause of loss.
10. "**Reasonable and Customary**" means, with regard to charges for dental services or supplies, the lowest of:
 - a. the usual charge by the provider for the same or similar dental services or supplies;
 - b. the usual charges of most providers of similar training and experience in the same or similar geographic area for the same or similar service or supplies; or
 - c. the actual charge for the services or supplies.

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

DENTAL CARE EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

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

- [18.] for precision or semi-precision attachments;
- [19.] for sealants;
- [20.] for plaque control;
- [21.] for acid etch;
- [22.] prescription or take-home fluoride;
- [23.] for oral hygiene instructions; and for (a) the completion of a claim form; (b) broken appointments; or (c) diagnostic photographs;
- [24.] for procedures that are begun, but not completed; and
- [25.] for fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.

**[OPTIONAL STUDENT
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)]**

Student Only Coverage

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

Reduction Schedule - Coverage terminates at age 65

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

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

[The Company will pay the following for the [accidental loss of] [total use of]:	
[Life	The maximum]
[A hand by severance through or above the wrist	1/2 the maximum]
[A foot by severance through or above the ankle	1/2 the maximum]
[Irrecoverable loss of sight of one eye	1/2 the maximum]]
[Speech or hearing	1/2 the maximum]]
[Quadriplegia*]	[The maximum]
[Paraplegia or Hemiplegia*]	[1/2 the maximum]
[Thumb and index finger of same hand]	[1/4 of the maximum]
[Both hands or both feet	The maximum]
[Sight of both eyes	The maximum]
[Combination of two: hand, foot or sight	The maximum]
[Speech and hearing	The maximum]
[One hand, one foot or sight of one eye	1/2 the maximum]
[Two or more Members**]	[The maximum]
[Irrecoverable loss of speech and hearing (both ears)]	[The maximum]
[One Member**]	[1/2 the maximum]
[Irrecoverable loss of speech or hearing (both ears)]	1/2 the maximum]

[** "Member" means hand, foot or eye.]

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

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

EXCEPTIONS AND EXCLUSIONS

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

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

BENEFICIARY

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

1. the Insured Student's spouse, if living;
2. the Insured Student's Children, in equal shares;
3. the Insured Student's parents, in equal shares, or to the surviving parent;
4. the Insured Student's brothers or sisters;
5. the Insured Student's estate (if no Beneficiary survives the Insured Student).

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

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

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

DEFINITIONS - Accidental Death and Dismemberment

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

1. "**Injury**" means an accidental bodily injury sustained by an Insured Student which results directly from an accident which occurs independent of any and all other causes.
2. "**Insured Student**" means an individual whose insurance coverage under this Policy is based on his/her status as an Eligible Student of the Policyholder.
3. "**Physician or Doctor**" means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual.

4. **"Policy"** means the Policy including all amendments, riders and endorsements.
5. **"Policyholder"** means the college, university, or other institution or organization the Policy is issued to, whether directly or on its behalf to a member or representative thereof.]

24/7 NURSE LINE

This service provides the student with 24 hour telephone access to a care specialist and nurses. Nurses can provide the student with easy to understand information on a wide range of health issues. The toll free number is [866-549-5076]. Students can access the Nurse Line 24 hours a day, 7 days a week.

Global Emergency Medical Evacuation – [Assist America]

In the event that an Insured Individual becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transportation necessary to evacuate an Insured Individual to the nearest facility capable of providing appropriate care. With one phone call, Assist America's team of professionals will handle the transportation arrangements to a more suitable hospital.

[Assist America's] medical personnel will also maintain regular communication with the Insured Individual's attending physician and/or hospital and relay any information to the Insured Individual's family.

For global emergency assistance call [Assist America's] toll free number, [800-872-1414], or if outside of the United States call collect at [609-452-8570].

Repatriation – [Assist America]

If an Insured Individual requires medical assistance upon being discharged from a hospital, Assist America will repatriate him/her home or to a rehabilitation facility with a medical or non-medical escort, as necessary. In the event of death of an Insured Individual, Assist America will render every possible assistance in returning the mortal remains including locating a funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport. An Assist America card will be supplied to the Insured Individual once the student has enrolled in the LowerMark health insurance plan.

The [Assist America] card must be carried at all times. For global emergency assistance or when the Insured Individual is 100 miles away from his/her primary residence a toll-free number is available, [800-872-1414], or if outside of the United States call collect at [609-452-8570].

CLAIMS PROCEDURE

Written notice of any event that may lead to a claim under the policy must be given to the Company or its authorized administrator within 60 days after the event, or as soon thereafter as reasonably possible. When the Company receives notice of the claim, We will send claim forms for filing.

Written proof of loss must be furnished to the Company within 90 days after the date of loss, or as soon thereafter as reasonably possible. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss.

Claim Payment

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

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

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

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

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

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

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

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

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

HIPAA

HIPAA Privacy: The Lewer Agency, Inc. and Trustmark Life Insurance Company value your privacy and have in place policies to protect your private health information. To view both of our HIPAA Privacy Policies, please see our website at www.LewerMark.com. A copy of the Trustmark Life Insurance Company policy notice is attached at the back of this Certificate. To obtain a copy of the Lewer policy, please contact The Lewer Agency, Inc., Privacy Officer, [4534 Wornall Road, Kansas City, Missouri, 64111, (816) 753-4390 or (800) 821-7715].

IMPORTANT NOTICE

This is only a summary of a master insurance policy (the Master Policy) issued to the Policyholder by the Company. The Master Policy contains language and provisions not contained in this brochure. In the event of a conflict between this brochure and the Master Policy, the Master Policy will govern.

Any provision of the Master Policy in conflict with the laws of the jurisdiction in which the Policyholder is located is hereby automatically amended to conform to the minimum requirement of those laws.

The Policyholder requires its outbound students and other persons of similar description to carry medical insurance coverage. This coverage must be accepted by the student unless proof of other coverage (acceptable to the Company) is provided.

For information and assistance, call the Lewer Agency at 1-800-821-7710.

**Insured By:
Trustmark Life Insurance Company**

SERFF Tracking Number: TRST-127168378 State: Arkansas
 Filing Company: Trustmark Life Insurance Company State Tracking Number: 48769
 Company Tracking Number: 11.00168
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: STUBLK R11-09 [MP]
 Project Name/Number: Student Health Policy Paragraph and Certs/11.00168

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/13/2011
Comments:			
Attachment:			
AR Flesch TML.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/13/2011
Comments:	The form number of the application is TLA-TLIC-BIApp and it was approved by your Department on 7/8/10 under DOI #46030.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	05/13/2011
Bypass Reason:	Not applicable. This is not a PPACA endorsement/contract filing.		
Comments:			

Trustmark
LIFE INSURANCE COMPANY

RE: Forms CE R11-09 AR (R1), et al

This is to certify the forms shown below comply with the requirements of Arkansas Stat. Ann. Sections 23-80-201 to 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch reading ease score of at least 40.

Sandra
Przybyszewski

Digitally signed by Sandra
Przybyszewski
DN: cn=Sandra Przybyszewski, c=US
Date: 2011.05.13 12:04:04 -05'00'

Sandra Przybyszewski
Vice President

ARKANSAS