

SERFF Tracking Number: ACEH-127967934 State: Arkansas
Filing Company: ACE Property and Casualty Insurance Company State Tracking Number:
Company Tracking Number: STUDENT ACCIDENT & SICKNESS
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student Accident & Sickness
Project Name/Number: Student Accident & Sickness/Student Accident & Sickness

Filing at a Glance

Company: ACE Property and Casualty Insurance Company
Product Name: Student Accident & Sickness SERFF Tr Num: ACEH-127967934 State: Arkansas
TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Approved- State Tr Num:
Closed
Sub-TOI: H04.001 Student Co Tr Num: STUDENT ACCIDENT State Status: Approved-Closed
& SICKNESS
Filing Type: Form Reviewer(s): Rosalind Minor
Authors: Karen Moore, Valeria Disposition Date: 01/11/2012
Porterfield, Ilona Slofer, Charles
Dooley, Maureen Ortega
Date Submitted: 01/10/2012 Disposition Status: Approved-
Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Student Accident & Sickness Status of Filing in Domicile: Not Filed
Project Number: Student Accident & Sickness Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Blanket Overall Rate Impact:
Filing Status Changed: 01/11/2012
State Status Changed: 01/11/2012 Deemer Date:
Created By: Charles Dooley Submitted By: Charles Dooley
Corresponding Filing Tracking Number:
PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null
Filing Description:
January 10, 2012

Insurance Commissioner Jay Bradford
Arkansas Insurance Department

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1200 West 3rd Street
Little Rock, AR 72201

Re: ACE Property and Casualty Insurance Company - NAIC Number 0626-20699
Student Accident and Sickness Insurance Policy
Policy Form AH-29564-AR, et al.

Dear Commissioner Bradford:

We respectfully submit the forms listed below for filing on behalf of ACE Property and Casualty Insurance Company for your review and approval. These forms are new and not intended to replace any forms currently on file. Pennsylvania, our domiciliary state, does not require the filing of forms intended for issue outside of the state. The following forms are enclosed:

Form Name Form Number

Student Accident and
Sickness Policy AH-29564-AR

Master Application AH-29565

Policy Amendment Rider AH-29566

Dental Expense Benefit Rider AH-29567

Vision Care Expense Benefit Rider AH-29568

Student Accident & Sickness Insurance Policy (AH-29564-AR) is designed to provide coverage on a blanket basis to students attending an educational institution. Coverage may also be extended to the dependents and spouses of students. This enclosed Student Accident and Sickness Policy and related forms and riders are intended to comply with the Patient Protection and Affordable Care Act (PPACA) of 2010.

The variable material in these forms has been indicated by brackets. Highlighted "Filing Notes" are embedded within the forms to provide explanations of variability. A Description of Variable Language is also enclosed.

We appreciate the advice previously given by the Department in preparation of this filing. If there are any questions or if additional information is required, please feel free to contact me at (732) 945-2320 or email

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Andrew.Mead@Combined.com. If it would facilitate your review, I would be happy to arrange a conference call, or at your discretion, a meeting to discuss any questions you may have.

Very truly yours,

Andrew Mead
 Director of Compliance

Company and Contact

Filing Contact Information

Charles Dooley, charles.dooley@acegroup.com
 436 Walnut Street 215-640-4958 [Phone]
 WA09D
 Philadelphia, PA 19106

Filing Company Information

ACE Property and Casualty Insurance CoCode: 20699 State of Domicile: Pennsylvania
 Company
 PO Box 1000 Group Code: 626 Company Type:
 436 Walnut Street Group Name: ACE Group State ID Number:
 Philadelphia, PA 19106 FEIN Number: 06-0237820
 (215) 640-5123 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? No
 Fee Explanation: \$50 per form x 5 forms = \$250
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ACE Property and Casualty Insurance Company	\$250.00	01/10/2012	55161060

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/11/2012	01/11/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/10/2012	01/10/2012	Charles Dooley	01/10/2012	01/10/2012

SERFF Tracking Number: ACEH-127967934 State: Arkansas
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Disposition

Disposition Date: 01/11/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ACEH-127967934 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	No
Supporting Document	Description of Variability	Approved-Closed	No
Supporting Document	Cover Letter	Approved-Closed	No
Form (revised)	Student Accident & Sickness Policy	Approved-Closed	Yes
Form	Student Accident & Sickness Policy	Replaced	Yes
Form	Student Accident & Sickness Application	Approved-Closed	Yes
Form	Student Accident & Sickness Amendatory Rider	Approved-Closed	Yes
Form	Student Accident & Sickness Dental Rider	Approved-Closed	Yes
Form	Student Accident & Sickness Vision Rider	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 01/10/2012

Submitted Date 01/10/2012

Respond By Date

Dear Charles Dooley,

This will acknowledge receipt of the captioned filing.

Objection 1

- Student Accident & Sickness Policy, AH-29564-AR (Form)

Comment:

Some benefits payable do not seem to be in compliance with our Bulletin 9-85 and 9-85A, which states in part that there can be no more than a 25% differential in payment between a PPO and Non-PPO. Some of your benefits payable (even though they are in variable brackets), indicate 100% vs 70%.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 01/10/2012
 Submitted Date 01/10/2012

Dear Rosalind Minor,

Comments:

Dear Ms. Minor,

Thank you for your consideration of this filing. I have addressed your objection below.

Response 1

Comments: I have revised the benefits to pay at least 75%.

Related Objection 1

Applies To:

- Student Accident & Sickness Policy, AH-29564-AR (Form)

Comment:

Some benefits payable do not seem to be in compliance with our Bulletin 9-85 and 9-85A, which states in part that there can be no more than a 25% differential in payment between a PPO and Non-PPO. Some of your benefits payable (even though they are in variable brackets), indicate 100% vs 70%.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Student Accident & Sickness Policy	AH-29564-AR		Policy/Contract/Fraternal Certificate	Initial		52.300	PPACA Policy AH-29564-

SERFF Tracking Number: ACEH-127967934 State: Arkansas
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AR_rev01
102012.pdf
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Previous Version

Student Accident & Sickness Policy	AH- 29564-AR	Policy/Contract/Fraternal Certificate	Initial 52.300	PPACA Policy AH- 29564- AR.pdf
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No Rate/Rule Schedule items changed.

Thank you again for your consideration of this filing.

Sincerely,

Charles Dooley

Sincerely,

Charles Dooley, Ilona Slofer, Karen Moore, Maureen Ortega, Valeria Porterfield

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Form Schedule

Lead Form Number: AH-29564-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/11/2012	AH-29564-AR	Policy/Cont	Student Accident & Fraternal Sickness Policy Certificate	Initial		52.300	PPACA Policy AH-29564-AR_rev01102012.pdf
Approved-Closed 01/11/2012	AH-29565	Application/Enrollment Form	Student Accident & Sickness Application	Initial		0.000	Generic PPACA Master Application AH-29565.pdf
Approved-Closed 01/11/2012	AH-29566	Policy/Cont	Student Accident & Fraternal Sickness Amending Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		50.000	Generic PPACA AMD Rider AH-29566.pdf
Approved-Closed 01/11/2012	AH-29567	Policy/Cont	Student Accident & Fraternal Sickness Dental Amending Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		51.200	Generic PPACA Dental Rider AH-29567.pdf
Approved-Closed 01/11/2012	AH-29568	Policy/Cont	Student Accident & Fraternal Sickness Vision Amending Rider Certificate:	Initial		50.900	Generic PPACA Vision Care AH-29568.pdf

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Product Name: Student Accident & Sickness
Project Name/Number: Student Accident & Sickness/Student Accident & Sickness
Amendmen
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ACE Property and Casualty
Insurance Company
(A Stock Company)
Philadelphia, PA 19106

Student Accident & Sickness Policy

ACE Property and Casualty Insurance Company agrees to provide the benefits shown in the Plan of Insurance with respect to each person insured for them under this Policy. The benefits will be paid in accordance with the provisions of this Policy.

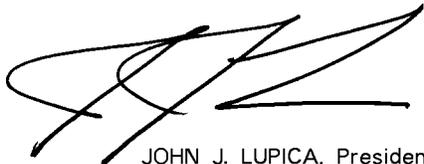
This Policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums as set forth herein.

This Policy takes effect as of 12:01 a.m., {Eastern Standard} Time, on its Policy Effective Date. This Policy ends as of 12:01 a.m., {Eastern Standard} Time, on its Policy Termination Date. These dates are shown in the Plan of Insurance.

The provisions on the pages which follow form a part of this Policy. This Policy is issued at the Administrative Office of ACE Property and Casualty Insurance Company on {January 1, 20XX}.

This Insurance Policy Number {CUH0123456} is issued to {ABC University}.
(the Policyholder)

For ACE Property and Casualty Insurance Company



JOHN J. LUPICA, President



CARMINE A. GIGANTI, Secretary

Your student health insurance coverage, offered by ACE Property and Casualty Insurance Company, may not meet the minimum standards required by title XXVII of the Public Health Services Act. Specifically, the coverage will not be renewed when you are no longer a student at {ABC University}; and the restrictions on annual dollar limits on your benefits may not be the same as other types of coverage. For policy years beginning before September 23, 2012, if a policy for student health insurance coverage applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$100,000. Your student health insurance coverage put an annual limit of {\$100,000 to unlimited} on “Essential Benefits” described in this Policy. If you have any questions or concerns about this notice, contact {1-800-352-4462.}

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[SECTION I - PLAN OF INSURANCE

{Filing Note: The Plan of Insurance is completely optional and variable. Benefits provided will be based on case-specific information, and will never be less than permissible under state laws.}

PPO PLAN DESIGN

Policyholder: {ABC University}
Policy Number: {CUH12345}
Policy Effective Date: {January 1, 20XX}
Policy Termination Date: {January 1, 20XX}

{Filing Note: The minimum Policy Aggregate Maximum Benefit for Essential Benefits will reflect the requirements of the Patient Protection and Affordable Care Act as shown below, which may be adjusted in accordance with changes in state or federal regulatory requirements:}

*Policy effective date prior to September 23, 2012: \$100,000
Policy effective dates September 23, 2012 through December 31, 2013: \$2,000,000
Policy effective dates January 1, 2014 and later: Unlimited*

Copayments may apply to one or more of the benefits listed below; limitations on the number of treatments covered for one or more of the benefits listed below may be included, (not applicable to Preventive Services).}

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil".

Policy Aggregate Maximum Benefit:

(for Essential Benefits only)

Per Insured Person: {\$100,000 - Unlimited}

{Filing Note: Plans will not impose deductibles, copayments or other forms of cost sharing that exceed the limits required by the Patient Protection and Affordable Care Act.}

Deductible per Policy Year (Not applicable to Preventive Services):

Network Provider: {\$100.00 - \$1,000} per Insured Person

Non-Network Provider: {\$100.00 - \$1,000} per Insured Person

Out-of-Pocket Maximum per Policy Year:

Network Provider: {\$1,000 - \$5,000} per Insured Person

Non-Network Provider: {\$1,000 - \$5,000} per Insured Person

COVERAGE

BENEFIT AMOUNT

ESSENTIAL BENEFITS:

HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Miscellaneous Hospital Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Surgery Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Multiple Surgical Procedure Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Anesthesia Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Assistant Surgeon Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

OUTPATIENT EXPENSE BENEFIT

Doctor's Office Visit Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Chiropractic Care Office Visit Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Hospital Outpatient Department Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Emergency Room Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{90% of R & C}
Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Radiation Therapy and Intravenous Chemotherapy Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Physical Therapy Expense Covered Percentage:	

Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Occupational Therapy Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Speech Therapy Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
High Cost Procedures Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

MENTAL OR NERVOUS DISORDERS EXPENSE BENEFIT

Inpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Outpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

ALCOHOL OR DRUG DEPENDENCY EXPENSE BENEFIT

Inpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}
Outpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

MATERNITY EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

AMBULANCE EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{90% of R & C}

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{75% of R & C}

LICENSED NURSE EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
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Non-Network Provider: {75% of R & C}

HOSPICE EXPENSE BENEFIT

Covered Percentage: Network Provider: {80% of R & C}
Non-Network Provider: {80% of R & C}

PRESCRIPTION DRUG EXPENSE BENEFIT

Copayment: Generic Drugs: {\$10.00 per prescription}
Brand Name Drugs
[Generic Not Available]: {\$15.00 per prescription}
Brand Name Drugs
[Generic Available]: {\$20.00 per prescription}

PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

SKILLED NURSING FACILITY EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

DIABETES EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

ENTERAL FOOD FORMULA EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

HEARING AIDS EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

OSTOMY EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

ASTHMA EDUCATION EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

MORBID OBESITY EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

DENTAL CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Dental Care Expense Benefit Rider

VISION CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Vision Care Expense Benefit Rider

CLINICAL TRIALS EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

PREVENTIVE SERVICES

(Covered charges for Preventive Services do not apply to the Policy Aggregate Maximum for Essential Benefits)

PREVENTIVE SERVICES FOR ADULTS EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

PREVENTIVE SERVICES FOR WOMEN EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

PREVENTIVE SERVICES FOR CHILDREN EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

MANDATED BENEFITS

CHILDREN'S PREVENTIVE HEALTH CARE EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

IN VITRO FERTILIZATION EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }
Benefit Maximum {\$15,000 per lifetime}

PHENYLKETONURIA EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

SPEECH OR HEARING LOSS OR IMPAIRMENT EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

Benefit Maximum for Hearing Aids

[Hearing Aid benefit not subject to Deductible or Copayment]:

[\$1,400 per ear for each 3-year period]

MUSCULOSKELETAL DISORDERS IN FACE, NECK OR HEAD EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C }

GENERAL ANESTHESIA FOR DENTAL CARE EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

PROSTATE CANCER SCREENING EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

{OPTIONAL BENEFIT PROVISIONS

(Covered charges for Optional Benefit Provisions do not apply to the Policy Aggregate Maximum for Essential Benefits)

ABORTION EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum {\$5,000 - \$50,000}

PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

STUDENT HEALTH CENTER REFERRAL

Included

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT – Per Accident [or Per Sickness]

Covered Percentage: {100% of actual Expense}
Benefit Maximum: {\$5,000 - \$50,000}

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage: {100% of actual Expense}
Benefit Maximum: {\$5,000 - \$50,000}

CONSULTANT EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

SICKNESS DENTAL EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}}

ALLERGY TESTING AND TREATMENT EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {75% of R & C}

Benefit Maximum: {\$100 - \$2,000 per Policy Year}

PODIATRIC EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}

Non-Network Provider: {75% of R & C}

Benefit Maximum: {\$100 - \$2,000 per Policy Year}

[SECTION I - PLAN OF INSURANCE

{Filing Note: The Plan of Insurance is completely optional and variable. Benefits provided will be based on case-specific information, and will never be less than permissible under state laws.}

INDEMNITY PLAN DESIGN

Policyholder: {ABC University}
Policy Number: {CUH12345}
Policy Effective Date: {January 1, 20XX}
Policy Termination Date: {January 1, 20XX}

{Filing Note: The minimum Policy Aggregate Maximum Benefit for Essential Benefits will reflect the requirements of the Patient Protection and Affordable Care Act as shown below, which may be adjusted in accordance with changes in state or federal regulatory requirements:}

*Policy effective date prior to September 23, 2012: \$100,000
Policy effective dates September 23, 2012 through December 31, 2013: \$2,000,000
Policy effective dates January 1, 2014 and later: Unlimited*

Copayments may apply to one or more of the benefits listed below; limitations on the number of treatments covered for one or more of the benefits listed below may be included, (not applicable to Preventive Services).}

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil".

Policy Aggregate Maximum Benefit:

(for Essential Benefits only)

Per Insured Person: {\$100,000 – Unlimited}

{Filing Note: Plans will not impose deductibles, copayments or other forms of cost sharing that exceed the limits required by the Patient Protection and Affordable Care Act.}

Deductible per Policy Year:

(Not applicable to Preventive Services)

[\$100.00 - \$1,000] per Insured Person

Out-of-Pocket Maximum per Policy Year:

{\$1,000 - \$5,000} per Insured Person

COVERAGE

BENEFIT AMOUNT

ESSENTIAL BENEFITS:

HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Miscellaneous Hospital Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Surgery Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Multiple Surgical Procedure Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Anesthesia Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Assistant Surgeon Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

OUTPATIENT EXPENSE BENEFIT

Doctor's Office Visit Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Chiropractic Care Office Visit Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Hospital Outpatient Department Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Emergency Room Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Diagnostic X-ray and Laboratory Testing Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Radiation Therapy and Intravenous Chemotherapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Physical Therapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Occupational Therapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Speech Therapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

High Cost Procedures Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

MENTAL OR NERVOUS DISORDERS EXPENSE BENEFIT

Inpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Outpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

ALCOHOL OR DRUG DEPENDENCY EXPENSE BENEFIT

Inpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Outpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

MATERNITY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

AMBULANCE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

LICENSED NURSE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

HOSPICE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

PRESCRIPTION DRUG EXPENSE BENEFIT

Copayment: Generic Drugs: {\$10.00 per prescription}
 Brand Name Drugs
 [Generic Not Available]: {\$15.00 per prescription}
 Brand Name Drugs
 [Generic Available]: {\$20.00 per prescription}

PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

SKILLED NURSING FACILITY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

DIABETES EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

ENTERAL FOOD FORMULA EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

HEARING AIDS EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

OSTOMY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

ASTHMA EDUCATION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

MORBID OBESITY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

DENTAL CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Dental Care Expense Benefit
 Rider

VISION CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Vision Care Expense Benefit
 Rider

CLINICAL TRIALS EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

PREVENTIVE SERVICES

(Covered charges for Preventive Services do not apply to the Policy Aggregate Maximum for Essential Benefits)

PREVENTIVE SERVICES FOR ADULTS EXPENSE BENEFIT

Covered Percentage: {100% of R & C}

PREVENTIVE SERVICES FOR WOMEN EXPENSE BENEFIT

Covered Percentage: {100% of R & C}

PREVENTIVE SERVICES FOR CHILDREN EXPENSE BENEFIT

Covered Percentage: {100% of R & C}

MANDATED BENEFITS

CHILDREN'S PREVENTIVE HEALTH CARE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

IN VITRO FERTILIZATION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Benefit Maximum {\$15,000 per lifetime}

PHENYLKETONURIA EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

SPEECH OR HEARING LOSS OR IMPAIRMENT EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Benefit Maximum for Hearing Aids
[Hearing Aid benefit not subject to Deductible or Copayment]: {\$1,400 per ear for each 3-year period}

MUSCULOSKELETAL DISORDERS IN FACE, NECK OR HEAD EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

GENERAL ANESTHESIA FOR DENTAL CARE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

PROSTATE CANCER SCREENING EXPENSE BENEFIT

{100% of R & C up to the first \$5,000
then 80% of R & C}

{OPTIONAL BENEFIT PROVISIONS

(Covered charges for Optional Benefit Provisions do not apply to the Policy Aggregate Maximum for Essential Benefits)

ABORTION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum {\$5,000 - \$50,000}

PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

STUDENT HEALTH CENTER REFERRAL

Included

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT – Per Accident [or Per Sickness]

Covered Percentage: 100% of actual Expense
Benefit Maximum: {\$5,000 - \$50,000}

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage: 100% of actual Expense
Benefit Maximum: {\$5,000 - \$50,000}

CONSULTANT EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

SICKNESS DENTAL EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}}

ALLERGY TESTING AND TREATMENT EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}

PODIATRIC EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}

SECTION II - SCHEDULE OF ELIGIBLE CLASSES

<u>CLASS</u>	<u>DESCRIPTION OF CLASS</u>
{ I.	All full-time students of the Policyholder who are enrolled for 12 credit hours or more per semester.
II.	Dependents of Insured Students, as defined in the Definitions Section of this Policy.}

SECTION III - SCHEDULE OF PREMIUM RATES

<u>CLASS OF INSURED PERSONS</u>	<u>TERM OF COVERAGE</u>	<u>PREMIUM RATE</u>
[Student Only	Annual	\$()
Spouse Only	Annual	\$()
Child(ren) Only	Annual	\$()
Student Only	Spring	\$()
Spouse Only	Spring	\$()
Child(ren) Only	Spring	\$()
Student Only	Summer	\$()
Spouse Only	Summer	\$()
Child(ren) Only	Summer	\$()]

SECTION IV - DEFINITIONS

{Filing Note: Definitions may vary based on the plan of benefits elected by the policyholder. They may appear here, in a general section, or elsewhere in the document as the terms are used.}

Whenever used in this Policy:

“Accident” means a specific unforeseen, unintended and unexpected event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

["Allowed Application Period" means a period of {15} days after the Policy Effective Date or for those students who start mid year, {15} days from the start of the {quarter} during which an eligible student may enroll and be covered as of the Policy Effective Date or the start of the {quarter}, respectively.]

"Coinsurance" means the percentage of Covered Charge or Expenses for which the Insured Person is responsible for a covered service.

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

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

Not included are: (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.]

["Copayment" means the specified dollar amount an Insured Person must pay for specified charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.]

“Covered Charge” or “Expense” as used herein means those charges for any treatment, services or supplies that are: [(a)] for Network Providers, not in excess of the Preferred Allowance; [(b)] [for Non-Network Providers,] not in excess of the Reasonable and Customary Expenses; [(c)] not in excess of the charges that would have been made in the absence of this insurance; and [(d)] incurred while this Policy is in force as to the Insured Person [except with respect to any expense payable under the Extension of Benefits].

[For purposes of the Extension of Benefits, if an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the {30} day period following such termination of insurance.]

"Covered Percentage" means that part of the Covered Charge that is payable by the Company after the Deductible or Copayment has been met.

"Custodial Care" means services and supplies, including room and board charges, which are furnished mainly to help a person meet his or her routine daily needs and can be furnished by someone who has no professional health care training.

["Deductible" means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.]

["Dependent" means: (a) the Insured Student's spouse [residing with the Insured Student] [or Domestic Partner residing with the Insured Student]; or (b) the Insured Student's Children under the age of {26 – 30} years. Coverage for newborn children will consist of coverage for Accident or Sickness, including:

- (a) necessary care or treatment of congenital defects;
- (b) birth abnormalities;
- (c) premature birth;
- (d) tests for hypothyroidism, phenylketonuria and galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants mandated by law;
- (e) routine nursery care; and
- (f) routine pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time].

Such coverage will start from the moment of birth. In the event additional premium is required for such child then the coverage will terminate 90 days from the date of birth unless written request to continue insurance is made to Us and the premium is paid within 90 days from the date of birth or before the next premium due date, whichever is later.

In the case of minor children under the Insured Student's charge, care and control for whom the Insured Student has filed a petition to adopt, coverage will be effective:

- (a) From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
- (b) On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage will be to the same extent as specified above. Any additional premium required for such child must be paid at the time application is made.

The term "children" includes an Insured Student's biological children; step-children; and adopted children.

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

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

[Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.]]

"Doctor" as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

[**"Domestic Partner"** means the [same][opposite] sex partner of an Insured Student who has filed a "Declaration of Domestic Partnership" with the Policyholder's administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.]

[**"Domestic Student"** is a student classified as a United States Citizen and a student classified by the United States Government as a Permanent Resident.]

"Effective Date" means the first date a student becomes covered under the Policy.

"Elective Treatment" means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

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

[**"Experimental or Investigational Care"** means a service or supply:

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

The advice of medical consultants and commonly recognized national medical organizations may be relied upon in determining which services or supplies are experimental or investigational.]

"Hospital" means a facility which meets all of these tests:

- (a) it provides inpatient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it operates and is licensed as a Hospital under the laws of the jurisdiction in which it is located.

Hospital does not include a place that operates mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

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

"Injury" means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

"Insured Person" means an Insured Student [and his or her covered Dependent(s)] while insured under this Policy.

"Insured Student" means a student of the Policyholder who is eligible and insured for coverage under this Policy.

["International Student" is a student classified by the United States Government as a Non-Immigrant holding an F-1, J-1, or M-1 Non-Immigrant Visa.]

"Loss" means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

"Medical Emergency" means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

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

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

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

["Network Providers" are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.]

["Non-Network Providers" have not agreed to any pre-arranged fee schedules.]

"Out-of-Pocket Maximum" means the maximum dollar amount an Insured Person is responsible to pay during a Policy Year. After an Insured Person has reached the Out-of-Pocket Maximum, We cover most benefits at 100% for the remainder of the Policy Year. Some benefits, however, will remain payable at the percentage shown in the Plan of Insurance. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Copayments. Penalties and amounts above the Reasonable and Customary Expense do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown in the Plan of Insurance.]

"Policy Aggregate Maximum" means for each Insured Person, the maximum amount of benefits payable for all Injuries and Sicknesses combined under the Student Health Insurance Policy each Policy Year.

"Policy Effective Date" means the date the Policy takes effect as shown in the Plan of Insurance.

"Policyholder" means the institution indicated on the face page of this Policy.

["Policy Termination Date" means the date the Policy ends as shown in the Plan of Insurance.]

"Policy Year" means the 12 month period beginning on the Policy Effective Date.

["Preferred Allowance" means the amount a Network Provider will accept as payment in full for Covered Charges.]

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

"Sickness" means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

"We", "Us" and "Our" mean ACE Property and Casualty Insurance Company.

"You" and "Your" mean the Insured Student.

SECTION V - EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL

This Policy takes effect as of the Policy Effective Date stated in the Plan of Insurance. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided in the General Provisions Section, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on the first anniversary of the Policy Effective Date or any date thereafter. We will give the Policyholder at least {sixty days} prior written notice. [We also reserve the right to refuse to renew this Policy.]

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

SECTION VI- EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE

EFFECTIVE DATE OF INSURED PERSON'S COVERAGE

The insurance of each Eligible Student shall take effect as follows:

- [(a) If an Eligible Student enrolls [and pays the premium] on or before the Policy Effective Date, coverage will begin on the Policy Effective date;]
- [(b) If an Eligible Student enrolls [and pays the premium] after the Policy Effective Date but within the Allowed Application Period, coverage will begin on the Policy Effective Date or the start of the term or semester in which the student has enrolled;]
- [(c) If an Eligible Student enrolls [and pays the premium] after the Allowed Application Period, coverage will begin on the day after the enrollment card [and premium] is received; or]
- [(d) If an Eligible Student enrolls [and pays the premium] on or before the Policy Effective Date and such student is a participant in intercollegiate sports or a school sponsored activity or requirement, coverage will begin on the date the eligible student is required to be on campus.]]

{Filing Note: The following Text may be included if dependent coverage is provided.}

[LATE ENROLLMENT FOR DEPENDENTS

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

- [(a) when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester [or pro-rated premium] is required even if the spouse is enrolled after the term has begun;]
- [(b) when he or she provides a signed affidavit of Domestic Partnership. Proof of Domestic Partnership may be required. Payment for the full semester [or pro-rated premium] is required even if the Domestic Partner is enrolled after the term has begun;]
- [(c) when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application must be submitted and coverage will be effective as specified in the definition of "Dependent". Payment for the full semester [or pro-rated premium] is required even if the Dependent child is enrolled after the term has begun; and]
- [(d) when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's

arrival following direct travel from the homeland. Payment for the full semester [or pro-rated premium] is required even if the Dependent is enrolled after the term has begun.;

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

TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates:

- [(a) on the date this Policy is terminated;] or
- [(b) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error;] or
- [(c) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person;] or
- [(d) on the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes;] or
- [(e) on the last day the Insured Student is required to be on campus at the Policyholder or, if the Policyholder has so elected, the anniversary of the Policyholder's Policy.]]

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

{Filing Note: The following Text may be included if it applies to the plan.}

[If a student loses eligibility under this Policy because he or she no longer qualifies under the terms described in the Master Policy, he or she may apply for continuation of coverage. The application must be made within 31 days of losing eligibility, and the applicable premium must be paid.]

SECTION VII – RENEWABILITY OF COVERAGE

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

[SECTION VIII - PRE-EXISTING CONDITIONS LIMITATION

(Not applicable to Insured Persons under age 19)

{Filing Note: Policies effective January 1, 2014 and later will not include Pre-existing Condition limitation}

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

The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student's effective date, and (b) We will pay only for Loss or expense incurred after such twelve (12) consecutive month period.

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

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

The Pre-existing Condition Waiting Period will not apply:

- (a) To pregnancy.
- (b) In the case of an Insured Person who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage.
- (c) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured Person held Creditable Coverage, and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

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

Definition

"Creditable Coverage" means health benefits or coverage provided to a person pursuant to:

- (a) A group health plan;
- (b) Health insurance coverage;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Sec. 1928 of that Title;
- (e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, Chapter 55 of title 10, U.S.C.;
- (f) A medical care program of the Indian Health Service or of a tribal organization;
- (g) A State health benefit risk pool;
- (h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, under chapter 89 of title 5, U.S.C.;
- (i) A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
- (j) A health benefit plan under Sec. 5(e) of the Peace Corps Act, 22 U.S.C. Sec. 2504(e).]

{Filing Note: The following Text may be included if it applies to the plan.}

[SECTION IX - CONTINUOUS INSURANCE

This Policy may be replacing a Prior Plan with another insurer.

Prior Plan means (a) the Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy; and (b) other policies providing Creditable Coverage as defined in this Policy.

"Injury" or "Sickness" shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the Policy Aggregate Maximum.

Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.]

SECTION X - COVERAGE

All benefits to this Policy are shown in the Plan of Insurance. The benefits are described on the pages attached to and made a part of this Policy.

ACCIDENT EXPENSE BENEFIT

When, by reason of Injury, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance. Benefits are paid in accordance with the schedule shown in the Plan of Insurance. When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth as a result of the Accident, We will pay for the Covered Percentage of the Covered Charges incurred, as shown in the Plan of Insurance. The Accident must have occurred while coverage under the Policy is in force as to the Insured Person incurring the expense. Charges applicable to this provision incurred during the continuation of coverage shall also be included in the term "Expense" but only while they are incurred.

What We pay is shown in the Plan of Insurance.

SICKNESS EXPENSE BENEFIT

When, by reason of Sickness, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay for the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance. The date of the first medical treatment for the Sickness must have occurred while coverage under this Policy is in force as to the Insured Person incurring the expenses. Charges applicable to this provision incurred during the continuation of coverage shall also be included in the term "Expense" but only while they are incurred.

What We pay is shown in the Plan of Insurance.

Charges that are not covered for Accident & Sickness Expense Benefits

Charges to buy or rent:

- Air conditioners;
- Air purifiers;
- [Motorized transportation equipment;]
- Escalators or elevators in private homes;
- Eye glass frames or lenses;
- Swimming pools or supplies for them;
- General exercise equipment.

HOSPITAL EXPENSE BENEFIT

Part A Hospital Room and Board Expense

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

Part B Miscellaneous Hospital Expense

{Filing Note: Covered expenses may vary at the request of the Policyholder, subject to the minimum standards of your state.}

Miscellaneous Hospital Expense includes expenses incurred for:

- (a) [anesthesia, anesthesia supplies and services;]
- (b) [operating, delivery and treatment rooms and equipment;]
- (c) [diagnostic x-ray and laboratory tests;]
- (d) [lab studies;]
- (e) [oxygen tent;]
- (f) [blood and blood services;]
- (g) [prescribed drugs and medicines;]
- (h) [medical and surgical dressings, supplies, casts and splints;]
- (i) [radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;]
- (j) [chemotherapy treatment with radioactive substances;]
- (k) [intravenous injections and solutions, and their administration;]
- (l) [physical and occupational therapy; and]
- (m) [other necessary and prescribed Hospital expenses.]

We will pay the Covered Percentage of the Covered Charge incurred by the Insured Person during the period of Hospital Confinement for which benefits are payable under Part A, Hospital Room and Board Expense above.

What We pay is shown in the Plan of Insurance.

SURGICAL EXPENSE BENEFIT

Part A Surgery Expense Benefit

When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Charges of the Surgical Expense, in connection with any one Surgical Procedure, subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Definitions

"Surgical Expense" means charges by a Doctor for:

- (a) a Surgical Procedure;
- (b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and
- (c) usual post-operative treatment.

"Surgical Procedure" means:

- (a) a cutting procedure;
- (b) suturing of a wound;

- (c) treatment of a fracture;
- (d) reduction of a dislocation;
- (e) radiotherapy;
- (f) electrocauterization;
- (g) diagnostic and therapeutic endoscopic procedures;
- (h) injection treatment for hemorrhoids and varicose veins;
- (i) an operation by means of a laser beam.

Part B Multiple Surgical Procedures Expense Benefit

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

Part C Anesthesia Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the Expenses incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

[Part D Assistant Surgeon Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the Expense incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[Part E Second Surgical Opinion Expense Benefit

We will also provide benefits to an Insured Person for a second opinion consultation by a board certified specialist on the need for non-emergency surgery which has been recommended by the Insured Person's Doctor. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any required x-rays and diagnostic tests done in connection with that consultation.

We will pay the Covered Charges incurred by the Insured Person as shown in the Plan of Insurance. [Any Deductible or Coinsurance is waived for Expenses incurred in connection with the Second Surgical Opinion.]

What We pay is shown in the Plan of Insurance.]

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Percentage of the Covered Charge incurred for such services, subject to the Deductible shown in the Plan of Insurance.

{Filing Note: Covered expenses may vary at the request of the Policyholder, subject to the minimum standards of your state.}

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

- [(a) one Doctor visit per day;]
- [(b) constant care and treatment while an Insured Person is confined in an intensive care unit;]
- [(c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors;]
- [(d) consultation by another Doctor when requested by the Insured Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.]]

What We pay is shown in the Plan of Insurance.

OUTPATIENT EXPENSE BENEFIT

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

What We pay is shown in the Plan of Insurance.

Outpatient Services

{Filing Note: Covered expenses may vary at the request of the Policyholder, subject to the minimum standards of your state.}

Covered Charges for "Outpatient Services" include the following services:

- (a) [a Doctor's office while not Hospital Confined;]
- (b) [chiropractic care up to the maximum shown in the Plan of Insurance;]
- (c) [a Hospital outpatient department or emergency room;]
- (d) [diagnostic x-ray and laboratory testing;]
- (e) [blood and blood services, if provided and billed by a Hospital or other facility;]
- (f) [physical and occupational therapy as shown in the Plan of Insurance;]
- (g) [radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;]
- (h) [radiological lab or other similar facility licensed by the state;]
- (i) [surgical dressings, splints, casts, and other devices used to correct fractures and dislocations;]
- (j) [speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment. Speech therapy must be in keeping with a Doctor's written order for type, frequency, and duration;]
- (k) [shots and injections when received in the Doctor's office.]

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

{Filing Note: This text may be excluded}

[High Cost Procedures

High Cost Procedures, as used herein, means an outpatient procedure costing over [\$200.00.]

Covered Charges for High Cost Procedures include, but are not limited to, charges for the following procedures and services:

- (a) [C.A.T. Scan;]
- (b) [Magnetic resonance imaging; and]
- (c) [Laser treatment.]

The covered percentage for High Cost Procedures is shown in the Plan of Insurance.

If, by reason of similar benefit provision elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.]

MENTAL OR NERVOUS DISORDERS EXPENSE BENEFIT

We will pay the Covered Percentage of Covered Charges incurred for Medically Necessary treatment of Mental or Nervous Disorders.

Benefits for such treatment will be paid as they would for any other Sickness, subject to the following:

- (a) Inpatient confinement including partial hospitalization must be in a Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Services, Division of Mental Health Services. Partial hospitalization means continuous treatment for at least 4 hours but not less than 16 hours in any 24 hour period.
- (b) Outpatient benefits will be provided for services furnished by a:
 - (1) Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Service, Division of Mental Health Services;
 - (2) Doctor licensed under the Medical Practices Act;
 - (3) licensed psychologist; or
 - (4) community mental health center or other mental health clinic certified by the Department of Human Service, Division of Mental Health Services.

What We pay is shown in the Plan of Insurance.

Definition

“Mental or Nervous Disorders”

This term means those conditions listed in the standard nomenclature of the American Psychiatric Association.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[ALCOHOL OR DRUG DEPENDENCY EXPENSE BENEFIT

We will pay the Covered Percentage of Covered Charges incurred for the Medically Necessary treatment for an Insured Person with Alcohol or Drug Dependency in a Hospital or an Alcohol and Drug Dependency Treatment Center.

Benefits for such treatment will be paid as they would for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

"Alcohol and Drug Dependency Treatment Center" is a public or private facility or unit of a facility engaged in providing 24 hour treatment for substance abuse, and which provides a program for treatment of such abuse pursuant to a written treatment plan approved and monitored by a Doctor, properly licensed or accredited by the Department of Human Services/Office on Alcohol and Drug Abuse Prevention. The facility or unit may be: a) within a Hospital or psychiatric hospital or attached to or be a freestanding unit of a general Hospital or psychiatric hospital; or b) a freestanding facility specializing in such treatment, but it does not include halfway houses or recovery farms.

"Alcohol or Drug Dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.]

MATERNITY EXPENSE BENEFIT

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

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

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

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

Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine

procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

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

Covered Charges also include Doctor prescribed pre-natal vitamins.

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

What We pay is shown in the Plan of Insurance.

AMBULANCE EXPENSE BENEFIT

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

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

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

What We pay is shown in the Plan of Insurance.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such Durable Medical Equipment, subject to the Deductible shown in the Plan of Insurance. We pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is our property and is to be returned to Us, at Our expense, upon completion of the Insured Person's need, if so requested by Us.

What We pay is shown in the Plan of Insurance.

Definition

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

HOME HEALTH CARE EXPENSE BENEFIT

We will cover charges for Home Health Care services furnished to an Insured Person. Such benefits must be provided by a licensed Home Health Agency.

What We pay is shown in the Plan of Insurance.

Definitions

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

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

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

LICENSED NURSE EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

HOSPICE EXPENSE BENEFIT

If an Insured Person is Terminally Ill and requires a coordinated plan of home and inpatient care, We will cover charges for hospice services furnished to the Insured Person on the same basis as any other Sickness. The services must be under active management through a licensed hospice and approved by Us.

Covered Services will include:

- (a) part-time intermittent home nursing care by or under the direction of a graduate Registered Nurse;
- (b) medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill Insured Person.
- (c) counseling, including dietary counseling, for the Terminally Ill Insured Person;

- (d) Family Counseling for the immediate family and the family caregiver before the death of the Terminally Ill Insured Person;
- (e) Bereavement Counseling for the immediate family or family caregiver of the Insured for at least the 6 month period following the Insured Person's death or 15 visits, whichever occurs first.

What We pay is shown in the Plan of Insurance.

Definitions

“Terminally Ill” means a medical prognosis given by a Doctor that the Insured Person's life expectancy is 6 months or less.

“Bereavement Counseling” means counseling provided to the immediate family or family caregiver of the insured after the Insured Person's death to help the immediate family or family caregiver cope with the death of the Insured Person.

“Family Counseling” means counseling given to the immediate family or family caregiver of the Terminally Ill Insured Person for the purpose of learning to care for the Insured Person and to adjust to the death of the Insured Person.

PRESCRIPTION DRUG EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires drugs, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such drugs and the Medically Necessary services associated with the administration of such drugs, subject to the Copayment shown in the Plan of Insurance.

The drugs must be prescribed by a Doctor. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

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

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

What We pay is shown in the Plan of Insurance.

PROSTHETIC APPLIANCE AND ORTHOTIC DEVICE EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic Appliance or Orthotic Device, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase, initial fitting, and needed adjustment of such appliances or devices, as shown in the Plan of Insurance.

We do not pay for the replacement of Prosthetic Appliances or Orthotic Devices more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria.

What We pay is shown in the Plan of Insurance.

Definitions

“Prosthetic Appliance” means an external appliance that: (1) is intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (2) is custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

Prosthetic Appliance does not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

“Orthotic Device” means an external device that: (1) is intended to restore physiological function or cosmesis to a patient; and (2) is custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: (1) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (2) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body

What We pay is shown in the Plan of Insurance.

SKILLED NURSING FACILITY EXPENSE BENEFIT

If an Insured Person requires continuing treatment in a Skilled Nursing Facility following hospitalization, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for treatment in such Skilled Nursing Facility.

The services must be Medically Necessary as a continuation of treatment for the condition for which the Insured Person was previously hospitalized. The Insured Person must be admitted to the Skilled Nursing Facility following a Medically Necessary Hospital stay.

We cover such charges the same way We treat Covered Charges for any Hospital Confinement.

What We pay is shown in the Plan of Insurance.

Definition

“**Skilled Nursing Facility**” means a facility that is primarily engaged in providing inpatient skilled nursing care and related services to patients requiring convalescent and rehabilitative care. The facility must:

- (a) be directed by a duly licensed Doctor;
- (b) provide continuous 24 hour a day nursing service by or under the supervision of a registered graduate professional nurse (RN);
- (c) maintain a daily medical record of each patient;
- (d) be operated pursuant to law and appropriately licensed or certified;
- (e) be certified by the Medicare program.

Such facility must not include any home, facility or part thereof, used primarily:

- (a) for rest or treatment of tuberculosis;
- (b) for the aged, or for the care of drug addiction;
- (c) for the care and treatment of mental diseases or disorders, or custodial or educational care.

DIABETES EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for medical equipment, medical supplies, and diabetes self-management training solely for the management and treatment of Diabetes.

Benefits for self-management training include one per lifetime training program per Insured Person with Diabetes provided by a health care provider upon certification by such provider giving the training that the Insured Person has successfully completed the training.

In addition to the one lifetime training program provided above, additional diabetes self-management training will be covered in the event that a Doctor prescribes additional training and it is Medically Necessary because of a significant change in the Insured Person’s symptoms or conditions.

The provider or diabetes educator shall only provide diabetes self-management training within his scope of practice after having demonstrated expertise in diabetes care and treatment. The provider or diabetes educator may only provide such training after having completed an education training program required by his licensing board when such program is in compliance with the National Standards for Diabetes Self-Management Education Program, developed by the American Diabetes Association. The Doctor must issue a written prescription ordering the training for the Insured Person or his parent, spouse or legal guardian. The training must be successfully completed by the diabetic Insured Person and parent, spouse or legal guardian. The provider must certify successful completion; and provide a written certification of such to the referring Doctor and to Us. We will not pay benefits unless and until the provider provides certification that the Insured Person has successfully completed the diabetes self-management training.

The diabetes education process for self-management training must include the following standards:

- (a) Needs Assessment. The health care provider must conduct an individualized educational needs assessment with the participation of the Insured Person, family, legal guardian, or

support systems to be used in the development of the educational plan and interventions. The educational needs assessment shall include, but not be limited to, the following:

- Health history;
 - Medical history;
 - Previous use of medication;
 - Diet history;
 - Current mental health status;
 - Use of health care delivery systems;
 - Life-style practices such as occupation, education, financial status, social and cultural and religious practices, health beliefs and attitudes or preventive behaviors;
 - Physical and psychological factors including age, mobility, visual acuity, manual dexterity, alertness, attention span, and ability to concentrate;
 - Barriers to learning such as education, literacy level, perceived learning needs, motivation to learn, and attitude;
 - Family and social support; and
 - Previous diabetes education, including actual knowledge and skills.
- (b) Education Plan. The provider must develop a written education plan in collaboration with the Insured Person, his parent, spouse or legal guardian from information obtained in the needs assessment, including the following:
- Desired patient outcomes;
 - Measurable, behaviorally-stated learner objectives; and
 - Instructional methods.
- (c) Education Intervention. The provider must create an educational setting conducive to learning with adequate resources for space, teaching and audio-visual aids to facilitate the educational process. The provider must use a planned content outline. The content outline must be provided based on the needs assessment
- (d) Evaluation of Learner Outcomes. The provider must review and evaluate the degree to which the Insured Person with diabetes is able to demonstrate diabetes self-management skills as identified by behavioral objectives.
- (e) Plan for Follow-up for Continuing Learning Needs. The provider must review the educational plan and recommend any additional educational interventions to meet continuing learning needs.
- (f) Documentation. The provider must maintain written files and thereby completely and accurately document the educational experiences provided, and communicate such to the referring Doctor.

Diabetic equipment, supplies and appliances include the following which are prescribed by a Doctor as Medically Necessary for an Insured Person with Diabetes:

- (a) Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
- (b) Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
- (c) Test strips for glucose monitors, which include all test strips approved by the FDA, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
- (d) Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method of monitoring.
- (e) Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge.

- (f) Injection aids, which include devices used to assist with insulin injection;
- (g) Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
- (h) Insulin pumps as prescribed by the Doctor and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
- (i) Oral agents for controlling the blood sugar level, which are prescription drugs;
- (j) Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Diabetes Self-Management Training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalization and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

"Diabetes" means and includes Type 1, Type 2, or gestational diabetes, diabetes insipidus, and other specific types, and diabetes mellitus, a common chronic, serious systemic disorder of energy metabolism which includes a heterogeneous group of metabolic disorders which can be characterized by an elevated blood glucose level. The terms diabetes and diabetes mellitus are considered synonymous and defined to include Insured Persons using insulin and not using insulin and Insured Persons with elevated blood glucose levels induced by pregnancy, or Insured Persons with other medical conditions or medical therapies which wholly or partially consist of elevated blood glucose levels.

"Diabetes Educator or Health Care Provider" means only a person, licensed by and who has completed the Arkansas State Board's educational program that is in compliance with the National Standards for Diabetes Self-Management Educational Programs as developed by the American Diabetes Association, and only those duly certified to instruct in diabetes self-management.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[ENTERAL FOOD FORMULA EXPENSE BENEFIT

We will cover charges for non-prescription enteral formulas for home use, which are Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis,

gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[HEARING AIDS EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Hearing Aids if the Hearing Aids are prescribed, fitted, and dispensed by a licensed audiologist. An Insured Person may choose a Hearing Aid that is priced higher than the amount payable under this benefit and may pay the difference between the price of the Hearing Aid and the amount payable under this benefit, without financial or contractual penalty to the provider of the Hearing Aid.

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

What We pay is shown in the Plan of Insurance.

Definition

"Hearing Aid" means a nondisposable device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by Insured Persons.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[OSTOMY EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. "Ostomy" includes colostomy, ileostomy and urostomy.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for any diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is Medically Necessary to treat conditions caused by congenital or developmental deformity, Injury, disease or Sickness.

Benefits are not provided for the care or treatment of the teeth or gums, for intraoral prosthetic devices, or for surgical procedures for cosmetic purposes.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[ASTHMA EDUCATION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for all medically appropriate and necessary asthma outpatient self-management training and educational services that the Insured Person's treating Doctor or other appropriately licensed health care provider, or a Doctor who specializes in the treatment of asthma, certifies are necessary for the treatment of asthma.

If certified as necessary, the asthma outpatient self-management training and educational services, to be provided to the Insured Person shall be provided through a program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes asthma education or management.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[MORBID OBESITY EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for treatment of Morbid Obesity through gastric bypass surgery or another surgical method that is:

- (a) recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity; and
- (b) consistent with criteria approved by the National Institutes of Health.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Morbid Obesity" means a Body Mass Index that is:

- (a) greater than 40 kilograms per meter squared; or
- (b) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

"Body mass index" means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[CLINICAL TRIALS EXPENSE BENEFIT RIDER

We will pay the Covered Percentage of the Covered Charges incurred for Routine Patient Care Costs that an Insured Person receives in connection with participating in a Clinical Trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved Clinical Trial.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Clinical Trial" means:

- (1) A clinical research study or clinical investigation the purposes of the prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening illness and is approved or funded in full or in part by one or more of the following:
 - (a) The National Institutes of Health;
 - (b) The Centers for Disease Control and Prevention;
 - (c) The Agency for Health Care Research and Quality;
 - (d) The Centers for Medicare and Medicaid Services;
 - (e) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
 - (f) The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
- (2) A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or

- (3) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Routine Patient Care Costs" means:

- (1) Items, drugs, and services that are typically provided absent a clinical trial;
- (2) Items, drugs, and services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- (3) Items, drugs, and services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Routine Patient Care Costs does not include the cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection and analysis needs; or items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.]

PREVENTIVE SERVICES FOR ADULTS EXPENSE BENEFIT

We cover charges for preventive services expenses for adults. These are for services rendered to an adult Insured Person. These services are limited to the following:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50 or at high risk for colorectal cancer
 - (a) Annual fecal occult blood test or annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; or
 - (b) Double-contrast barium enema every five (5) years;
 - (c) Colonoscopy every ten (10) years
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:

- (a) Hepatitis A
 - (b) Hepatitis B
 - (c) Herpes Zoster
 - (d) Human Papillomavirus
 - (e) Influenza
 - (f) Measles, Mumps, Rubella
 - (g) Meningococcal
 - (h) Pneumococcal
 - (i) Tetanus, Diphtheria, Pertussis
 - (j) Varicella
 - (k) HPV
12. Obesity screening and counseling for all adults
 13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
 14. Tobacco Use screening for all adults and cessation interventions for tobacco users
 15. Syphilis screening for all adults at higher risk

What We pay is shown in the Plan of Insurance.

PREVENTIVE SERVICES FOR WOMEN EXPENSE BENEFIT

We cover charges for preventive services expenses for women. These are for services rendered to an woman Insured Person. These services are limited to the following:

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast Cancer Mammography screenings:
 - a. One baseline Mammogram for a woman thirty-five through thirty-nine years of age;
 - b. One Mammogram every twelve or twenty-four months for a woman forty through forty-nine years of age, inclusive, based on the recommendation of a Doctor;
 - c. One Mammogram every twelve months for a woman fifty years of age or older;
 - d. Upon recommendation of a woman's Doctor, without regard to age, where such woman has had a prior history of breast cancer or where such woman's mother or sister has had a history of breast cancer.
5. Breast Cancer Chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk

9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
16. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services for women under 65

What We pay is shown in the Plan of Insurance.

PREVENTIVE SERVICES FOR CHILDREN EXPENSE BENEFIT

We cover charges for preventive services expenses for women. These are for services rendered to an woman Insured Person. These services are limited to the following:

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood Pressure screening for children
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders
10. Fluoride Chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns

12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - (a) Diphtheria, Tetanus, Pertussis
 - (b) Haemophilus influenzae type b
 - (c) Hepatitis A
 - (d) Hepatitis B
 - (e) Human Papillomavirus
 - (f) Inactivated Poliovirus
 - (g) Influenza
 - (h) Measles, Mumps, Rubella
 - (i) Meningococcal
 - (j) Pneumococcal
 - (k) Rotavirus
 - (l) Varicella
18. HPV vaccines for children from age 7 to age 18
19. Iron supplements for children ages 6 to 12 months at risk for anemia
20. Lead screening for children at risk of exposure
21. Medical History for all children throughout development
22. Obesity screening and counseling
23. Oral Health risk assessment for young children
24. Phenylketonuria (PKU) screening for this genetic disorder in newborns
25. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
26. Tuberculin testing for children at higher risk of tuberculosis
27. Vision screening for all children

What We pay is shown in the Plan of Insurance.

[CHILDREN'S PREVENTIVE HEALTH CARE EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Periodic Preventive Care Visits, provided by or under the supervision of a single Doctor per visit, from the moment of birth through age 18 years. Periodic Preventive Care Visits include 20 visits at approximately the

following intervals: 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 Periodic Preventive Care Visits: (a) will be reimbursed at levels that will not exceed those established for the same services under the Medicaid program of the State of Arkansas; and (b) except for recommended immunization services, are subject to any applicable deductible, coinsurance and maximum amounts.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Children's Preventive Health Care" means Doctor-delivered or Doctor-supervised services for a covered Dependent child from the moment of birth through 18 years of age. Periodic Preventive Care Visits include medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

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

[IN VITRO FERTILIZATION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for in vitro fertilization services, including cryopreservation, subject to the following:

- (a) Participants must be interspousal with respect to donor and recipient; and
- (b) There must be a documented two year history of unexplained infertility; or
- (c) Infertility is associated with one or more of the following conditions:
 - (1) Endometriosis;
 - (2) DES;
 - (3) Blockage or removal of one or both fallopian tubes not a result of voluntary sterilization;
 - (4) Contributing abnormal male factors.

Expenses incurred for in vitro fertilization services are covered to the same extent and subject to the same policy provisions as any other maternity related expenses. The lifetime maximum benefit is \$15,000.

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

What We pay is shown in the Plan of Insurance.]

[PHENYLKETONURIA EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for amino acid modified preparations, Low Protein Modified Food products and formulas for therapeutic treatment of an Insured Person with phenylketonuria if:

- (a) The Medical Food or Low Protein Modified Food products are prescribed as Medically Necessary for phenylketonuria;
- (b) The products are administered under the direction of a Doctor; and
- (c) The cost of the Medical Food or Low Protein Modified Food products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year per person income tax credit allowed under Arkansas law.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one gram of protein per service and intended to be used under the direction of a Doctor for the dietary treatment of an inherited metabolic disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Doctor.]

[SPEECH OR HEARING LOSS OR IMPAIRMENT EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary treatment for Loss or Impairment of Speech or Hearing.

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

What We pay is shown in the Plan of Insurance.

Definition

"Loss or Impairment of Speech or Hearing" includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his or her area of certification.]

[MUSCULOSKELETAL DISORDERS IN FACE, NECK OR HEAD EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary treatment and diagnosis of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of Accident, trauma, congenital defect, developmental defect or pathology.

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

What We pay is shown in the Plan of Insurance.]

GENERAL ANESTHESIA FOR DENTAL CARE EXPENSE BENEFIT

We will pay the expenses incurred to cover general anesthesia and associated facility charges for dental procedures rendered in a Hospital or general surgery center when the clinical status or underlying medical condition of an Insured Person requires dental procedures that ordinarily would not require anesthesia in a Hospital or surgery center setting.

This benefit applies only to general anesthesia and associated facility charges and only for the following Insured Persons:

1. Insured Persons who are under seven (7) years of age;
2. Insured Persons who are developmentally disabled, regardless of age; or
3. Insured Persons whose health is compromised or for whom general anesthesia is necessary, regardless of age.

We will not cover the charges for the dental procedure itself, including the professional fee of the dentist. Coverage for anesthesia and associated facility charges will be subject to all other terms and conditions of this Policy the same as for any other covered Injury or covered Sickness. We will not provide benefits under this provision for anesthesia or related facility charges for dental procedures that ordinarily would require general anesthesia and that do not meet the requirements of items 1, 2, or 3 of this benefit.

Coverage for general anesthesia and associated Hospital or ambulatory facility charges is restricted to dental care that is provided by:

- (a) a fully accredited specialist in pediatric dentistry;
- (b) a fully accredited specialist in oral and maxillofacial surgery; and
- (c) a dentist to whom Hospital privileges have been granted.

This benefit does not cover dental care rendered for temporomandibular joint disorders.

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

What We pay is shown in the Plan of Insurance.

PROSTATE CANCER SCREENING EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for an annual screening for the early detection of prostate cancer in men over age 40 who are covered under the policy.

Benefits shall not exceed the actual charge for such screening, subject to the maximum shown in the Plan of Insurance.

The screening must be performed by a qualified medical professional. This includes a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant. The screening will consist, at a minimum, of the following tests:

- (a) a prostate-specific antigen (PSA) blood test;
- (b) digital rectal examination.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that this benefit is not subject to any Deductible provision.

What We pay is shown in the Plan of Insurance.

{Filing Note: this benefit is optional and may be included as shown or omitted}

[ABORTION EXPENSE BENEFIT

If as a result of pregnancy an Insured Person has a voluntary abortion, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance. Expenses for the voluntary abortion must be incurred while the Policy is in force as to the Insured Person.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Principal Sum referred to in this provision is shown in the Plan of Insurance.

When, because of an Injury, the Insured Person suffers any of the following Losses within [180] days from the date of the Accident, We will pay as follows:

For Loss Of:

[Life	Principal Sum
Two hands	{One-half of Principal Sum - Principal Sum}
Two feet	{One-half of Principal Sum - Principal Sum}
Sight of two eyes	{One-half of Principal Sum - Principal Sum}
One hand and one foot.....	{One-half of Principal Sum - Principal Sum}
One hand and sight of one eye.....	{One-half of Principal Sum - Principal Sum}
One foot and sight of one eye.....	{One-half of Principal Sum - Principal Sum}
One hand or one foot or one eye.....	{One-half of Principal Sum - Principal Sum}
[Thumb and Index Finger of Either Hand{One Quarter of Principal Sum - One-half of Principal Sum}]]	

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. [Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.]

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

[This provision does not cover the Loss if it in any way results from or is caused or contributed:

- [(1) By suicide, attempted suicide, or intentionally self-inflicted injury;]
- [(2) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;
- [(3) By an infection, unless it is caused solely and independently by a covered Accident;
- [(4) [For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or]
- [(5) [While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.]

In addition to the above, this provision is subject to the Exclusions as provided.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[PRE-ADMISSION TESTS EXPENSE BENEFIT

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

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

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

This provision shall apply with respect to the Insured Person only to the extent that the Insured Person is insured under this Policy for Hospital Expense Benefits.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[STUDENT HEALTH CENTER REFERRAL

In order to obtain the maximum benefit available when medical treatment is needed, the Insured Student must go to the Student Health Center (SHC) first where treatment will be administered or a referral issued. [Such charges are subject to the Deductible.] Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained [are excluded from coverage] [will be paid at {80%} of the benefits otherwise payable under the Plan of Insurance]. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary only under the following conditions:

- (1) [Medical Emergency; (The student [and Dependent] must return to SHC for necessary follow-up care.)]
- (2) [When the Student Health Center (SHC) is closed;]
- (3) [When service is rendered at another facility during break or vacation periods;]
- (4) [Medical care received when the student is more than {50 miles} from campus;]
- (5) [Medical care obtained when a student is no longer able to use the SHC due to a change in students status;]
- (6) [Maternity;]
- (7) [Gynecological Services; or]
- (8) [Psychotherapy.]

[Dependents are not eligible to use the SHC; and therefore, are exempt from the above limitations and requirements.]]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to [Domestic Students while studying in the United States][or][Domestic Students while studying abroad outside their Home Country [and their eligible Dependents while accompanying the student],][International Students studying abroad while outside their Home Country [and their eligible Dependents while accompanying the student],]. We will pay benefits for the Covered Percentage of the Covered Charge incurred, if any Injury [or Sickness] results in the Emergency Medical Evacuation of the Insured Person.

We will pay, subject to the limitations set forth below, for Eligible Emergency Medical Evacuation Expenses reasonably incurred if the [Domestic Student,] [International Student,] [or] [his or her eligible Dependent] suffers an Injury [or Sickness] that warrants his or her Emergency Medical Evacuation. The Injury [or Sickness] must occur while the [Domestic Student [and his or her eligible Dependents while accompanying the student] [is] [are] outside a {100,150,200} mile radius from the Domestic Student's current place of primary residence] [or] [International Student [and their eligible Dependents while accompanying them] outside the International Student's Home Country]. The Emergency Medical Evacuation Benefit is subject to the Maximum Amount shown in the Schedule of Benefits for the Emergency Medical Evacuation Benefit.

We [or Our authorized representative] must authorize all Emergency Medical Evacuation expenses in advance for this benefit to be payable. We reserve the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Us [or Our authorized representative] in advance.

Definitions

"Eligible Emergency Medical Evacuation Expenses" – as used in this Benefit, means an expense that: (1) is charged for Medically Necessary Emergency Medical Evacuation services; (2) does not exceed the usual level of charges for similar treatment, services, supplies or Transportation in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

"Emergency Medical Evacuation" - as used in this Benefit, means, if warranted by the severity of the Insured Person's Injury [or Sickness]:

- (1) the Insured Person's immediate Transportation from the place where the Injury [or Sickness] is suffered to the nearest Hospital, or other medical facility where appropriate medical treatment can be obtained;
- (2) Transportation to [the Domestic Student's current place of primary residence] [or] [the International Student's Home Country] to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury [or Sickness] and being treated at a local Hospital or other medical facility, limited to one transportation for the same related Injury [or Sickness]; or

(3) both (1) and (2) above. An Emergency Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

"Home Country" means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country [declared with Us].

"Medically Necessary Emergency Medical Evacuation Service" - as used in this Benefit, means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Medical Evacuation due to the Injury [or Sickness] for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.

"Transportation" – as used in this Benefit, means moving the Insured Person by an air, land or water conveyance during an Emergency Medical Evacuation. Conveyances include, but are not limited to, air or land ambulances and private motor vehicles.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

If Injury [or Sickness] to the Insured Person results in loss of life, We will pay, subject to the limitations set forth below, for Covered Repatriation of Remains Expenses which are reasonably incurred to return his or her body to his or her current place of primary residence. The Injury [or Sickness] must occur while the Insured Person is outside a {100,150,200} mile radius from his or her [current place of primary residence] [or] [Home Country]. Repatriation of Remains Benefits are subject to the Maximum Amount allowed shown in the Schedule of Benefits.

We [or Our authorized representative] must authorize all Repatriation of Remains expenses in advance of the actual repatriation for this benefit to be payable. We reserve the right to determine the benefit payable if it was not reasonably possible to contact Us [or Our representative in advance. All determinations and payments by Us will be final and fully release and discharge Us from any further liability under this Repatriation of Remains Benefit.

Definitions

"Covered Repatriation of Remains Expense" – as used in this benefit, means expenses limited to: (1) embalming or cremation; (2) the most economical coffin or receptacle adequate for transportation of the remains; and (3) transportation of the remains by the most economical and direct conveyance and route possible.

"Home Country" means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country [declared with Us].]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[CONSULTANT EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Charges incurred.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[SICKNESS DENTAL EXPENSE BENEFIT RIDER

If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[ALLERGY TESTING AND TREATMENT EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for diagnostic testing and treatment of allergies and immunology services. Coverage includes, but is not limited to, the following:

- (1) laboratory tests;
- (2) physician office visits, including visits to administer injections;
- (3) prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and
- (4) other medically necessary supplies and services.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[PODIATRIC EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for podiatric services provided on an outpatient basis following an injury.

We will not cover expenses for routine foot care, such as trimming of corns, calluses, and nails.

We cover such charges the same way We treat Covered Charges for any other Injury.

What We pay is shown in the Plan of Insurance.]

SECTION XI – EXCLUSIONS

{Filing note: Exclusions are filed as variable and may be modified at the policyholder's request based on the experience of its plan of benefits.}

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;]
2. [Pre-existing Conditions as defined in this Policy;]
3. [Nonprescription drugs or medicines unless prescribed by a Doctor;]
4. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;]
5. [Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;]
6. [Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;]
7. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]
8. [Correction of congenital defects except as specifically provided;]
9. [Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]
10. [Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy, or the Dental Care Expense Benefit Rider. This exclusion does not apply to treatment resulting from Injury to natural teeth.]
11. [Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;]
12. [Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community;]
13. [Injury or Sickness resulting from declared or undeclared war; or any act thereof;]
14. [Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;]

15. [Injury due to participation in a riot;]
16. [Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;]
17. [For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;]
18. [For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;]
19. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]
20. [Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;]
21. [Marriage, family, and group counseling;]
22. [Services or supplies primarily for educational, vocational or training purposes, except the initial visit to diagnose and determine if a medical condition is causing a learning disability;]
23. [Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury. This exclusion does not apply to any benefits specifically provided in an attached Amendatory Rider;]
24. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]
25. [Expenses for any service or supply not specified in this Policy as a covered service;]
26. [An amount of a charge in excess of the Reasonable and Customary Expense;]
27. [Elective Treatment or elective surgery, except as specifically provided;]
28. [Services not Medically Necessary;]
29. [Expenses for emergency room treatment for an Injury or Sickness not a Medical Emergency as defined in this Policy, including emergency "follow-up" visits;]
30. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;]
31. [Voluntary or elective abortion; pregnancy of a dependent child, except as specifically provided;]

32. [Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs except as noted, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery; Doctor-prescribed Viagra will be limited to six (6) tablets per month;]
33. [Medicines not taken in the dosage or the purpose prescribed by the Insured Person's Doctor;]
34. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit; pre-natal vitamins, except as specifically provided;]
35. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition, except as specifically provided;]
36. [Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;]
37. [Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;]
38. [Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;]
39. [Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;]
40. [Expense for hair replacement, wigs or wig maintenance;]
41. [Services that have already been paid by another insurance carrier, even if those services would have otherwise been covered by this Plan. Our Plan is secondary when the Insured Person is insured by more than one U.S. insurance company. However, this does not apply to the medical portion of automobile insurance;]
42. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy;]
43. [Care, treatment or supplies furnished by a program or agency funded by any government;]
44. [Hospital inpatient admissions primarily for diagnostic studies when bed care is not Medically Necessary;]
45. [Expenses for Experimental or Investigative treatments, except as specifically provided;]
46. [[Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.]

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

SECTION XII - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. The entire contract is made up of: (a) this Policy, including Your Application; and (b) the individual applications, if any, of Insured Persons. Statements made by the Policyholder or an Insured Person shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance, unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person, or to his/her beneficiary. No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidenced by endorsement on this Policy, or by amendment of this Policy signed by Us. No agent has authority to change this Policy or to waive any of its provisions.

GRACE PERIOD. A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. You shall be liable to Us for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to Us within {30 days} after the occurrence or commencement of any Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us at Our Administrative Office or to any authorized agent, with information sufficient to identify the Insured Person, shall be deemed notice to Us.

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

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

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

PAYMENT OF CLAIMS. All benefits for Loss other than death, will be paid to the Insured Student. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. It is not required that the service be rendered by a particular Hospital or person. The Insured Person must make a written request to Us before We can do this. We must receive the request no later than the time for filing proof of Loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured Student. This choice must be in writing and filed with Us. If the Insured Student has not chosen a beneficiary, or if there is no beneficiary alive when the student dies, We will pay:

- (a) his/her parents or legal guardian, if a minor;
- (b) otherwise, We will pay his/her estate.

We will pay these benefits immediately upon receipt of due written proof of such Loss.

PHYSICAL EXAMINATION. At Our own expense, We have the right to have a Doctor examine an Insured Person when and so often as We deem reasonably necessary while there is a claim

pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

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

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

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

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

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

{Filing Note: this provision is optional and may be omitted}

[PREMIUM REFUND POLICY. If an Insured Student withdraws from the university within the first {10 days} of the first semester, and has not yet submitted a claim, he or she will receive a full refund of the insurance premium. If an Insured Student withdraws from the university after {10 days} of the first semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium. If the Insured Student withdraws: (a) other than due to entering any military service; and (b) after the first {10 days} of the semester, no premium refund will be made.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.]

[The Insured Person may cancel their coverage within {10 working days} of the Effective Date of coverage by submitting a request for cancellation in writing to the university. Under no circumstances will a cancellation refund be provided if the Insured Person has filed a claim with Us.]

{Filing Note: this provision is optional and may be omitted}

[SECTION XIII - COORDINATION OF BENEFITS

This section will be used to determine an Insured Person's benefits under this Policy IF:

the Insured Person is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans,

and

the benefits that would be paid by this Policy, without this section

PLUS

the benefits that would be paid by the other Plans, without a section similar to this section
WOULD EXCEED ALLOWED EXPENSES as defined below.

DEFINITIONS:

PLAN means a plan which provides benefits or services for, or by reason of, hospital, surgical, medical, or dental care or treatment through:

1. group, blanket or franchise insurance coverage; this does not apply to blanket school accident only coverages;
2. pre-paid plans for:
 - group hospital service;
 - group medical service;
 - group practice;
 - Individual practice; and
 - any other such plans for members of a group;
3. any plan provided by:
 - labor management trusts;
 - unions;
 - employer organizations;
 - professional organization; or
 - employee benefit organizations;
4. a government program, or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. any group or group type hospital indemnity of more than \$200.00 per day;
6. Medicare (Title XVIII of the Social Security Act); and
7. any part of a state auto reparation or indemnity act (no fault insurance) with which the state permits coordination.

Plan does not include individual or family policies; individual or family subscriber contracts except as stated. Nor does it include any group or group type hospital indemnity of \$200.00 or less per day; or medical payment benefits customarily included in the traditional automobile contracts.

THIS PLAN means the medical care benefits provided by this Policy.

ALLOWED EXPENSE means an expense which is:

- necessary, reasonable and customary;
- incurred while the person (for whom the claim is made) is insured, or is entitled to benefits after insurance ends, under this Policy; and
- at least partly covered under one of the plans covering such Insured Person.

When this plan does not pay its benefits first, "Allowed Expense" will not include an expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an allowed expense and a benefit paid.

EFFECT ON BENEFITS UNDER THIS PLAN

When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a calendar year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any calendar year, the sum of all benefits to be paid to a person (by this and all other plans) equals the allowed expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

RULES TO DETERMINE WHICH PLAN PAYS FIRST

A plan, or part of one, that does not have a section similar to this section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be:

1. The plan which covers the Insured Person as an employee rather than as a full or part-time student.

Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3 or 4 will determine which plan pays first.

2. If 1 does not apply, the plan which covers the person as a full or part-time student rather than as a dependent.
3. If 1 and 2 do not apply, the plan which covers the person as a dependent of the parent whose month and date of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with custody rather than as a dependent of the parent without custody. If the parent with custody remarries:
 - the plan which covers the child as a dependent of a parent with custody will pay its benefits first;
 - the plan which covers the child as a dependent of a stepparent will pay its benefits next; and
 - the plan which covers the child as a dependent of a parent without custody will pay its benefits last.

A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.

4. If 1, 2, or 3 do not apply, the plan which has covered the insured person for the longer time rather than the shorter time.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For this section to work, We must exchange information with other plans. To do so, We may give to, or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Us the required information.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.]

SECTION XIV – APPEALS PROCEDURES

Internal Appeals:

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

External Appeals:

If the Insured person is not satisfied with the Internal Appeals determination, External Appeal for an adverse determination (involving a determination of medical necessity) may be requested. An Insured Person may apply to the External Appeals Panel to seek continued treatment during the course of External Appeal, and the External Appeal Panel may order continued treatment if substantial harm may result due to the absence of continued treatment, upon a showing proof of substantial harm.

An Insured Person may request an External Appeal by filing a request in writing, with the External Appeals Panel of your state's Department of Insurance. This must be done within four (4) months of receipt of written notice of the final adverse determination, provided, however, that no final adverse determination is necessary where the carrier has failed to comply with timelines for internal appeal process or if the insured or his or her authorized representative is requesting an expedited external appeal at the same time that he or she is requesting an expedited internal appeal.

The Insured Person may also request an expedited External Appeal by including a certification, in writing, from the Insured Person's Doctor that delay will pose a serious and immediate threat to the Insured Person's health.

{Filing Note: this provision is optional and may be omitted}

[SECTION XV - SUBROGATION AND RECOVERY RIGHTS

RIGHT TO SUBROGATION: If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Insured Person will do what ever is necessary to enable Us to exercise Our right and will do nothing after Loss to prejudice it. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

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

LIMITATION TO OUR RECOVERY RIGHTS: We may exercise Our Right to Subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under the Policy. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a responsible third party.]

SECTION XVI - EXTENSION OF BENEFITS

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense" until such Hospital Confinement ends or until the maximum benefits available under the Policy are paid, whichever occurs first.

SECTION XVII - CONSUMER INFORMATION NOTICE

The Insurance Company may be contacted at its [Administrative Office]:

ACE Property and Casualty
Insurance Company
436 Walnut Street
Philadelphia, PA 19106
1-800-123-4567]

The Insurance Agent may be contacted at:

[Joseph Agent
123 Main Street
Anytown, AR 12345
1-800-123-4567]

The State Insurance Department may be contacted at:

Arkansas Insurance Department
[1200 West Third Street
Little Rock, AR 72201-1904
1-800-282-9134]

SECTION XVIII - GUARANTY ASSOCIATION NOTICE

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which benefits could be provided out of the assets of the impaired or insolvent insurer.

7. Insurance will become effective as to each Eligible Person for whom application is received by the Company as of: [First day of class, Fall semester]
8. The Agent appointed by the Policyholder is: [ABC Brokerage]
9. The Policy will be issued for a term beginning at 12:01 A.M., [Eastern Standard] Time, on [June 1, 20XX], at the address of the Policyholder and ending at the same hour on [June 1, 20XX].

(See SECTION I - PLAN OF INSURANCE in the Policy for coverage details.)

All statements in the application for coverage under the Policy shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Policy, unless the statements are in the application or papers attached to the Policy.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

All statements in this application are considered to be true and complete to the best of our knowledge and belief.

For the Policyholder:

Name: [ABC University]

Signature: _____

Title: _____

Date: _____]



POLICY AMENDMENT

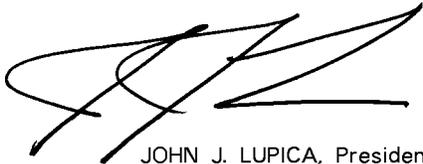
The rider is attached to and made part of Policy No. **[NUH0123456]** issued by ACE Property and Casualty Insurance Company to **[ABC University]**.

Effective **[January 1, 20XX]**, the Policy as issued is amended as follows:

[AMENDATORY RIDER

Administrative Purposes Only:]

For ACE Property and Casualty Insurance Company



JOHN J. LUPICA, President



CARMINE A. GIGANTI, Secretary



POLICY AMENDMENT

The rider is attached to and made part of Policy No. **{NUH0123456}** issued by ACE Property and Casualty Insurance Company to **{ABC University}**.

Effective **{January 1, 20XX}**, the Policy as issued is amended as follows:

DENTAL CARE EXPENSE BENEFIT RIDER

[Benefits under this Rider are available only to Insured Dependent children]

ELIGIBILITY

To be eligible for dental benefits of this Policy, the Insured Student and his or her Dependents must also be covered under the medical portion of this Policy.

DEFINITIONS

Accumulation Period means the period, which begins on the Policy Effective Date and ends on the Policy Termination Date of each year. [Covered Expenses incurred during the last three months of a Policy Year which are not payable because the Deductible was not met, may be carried over to the next Policy Year.]

Covered Expenses means We only cover expenses incurred for dental care or supplies that are:

- (a) Medically Necessary;
- (b) ordered by a Doctor or Dentist;
- (c) not excluded by the Exclusions;
- (d) listed below in the Covered Dental Services provision.

Dentist means any dental or medical practitioner, who is properly licensed or certified under the laws of the state and is acting within the scope of his or her license, to: (a) render dental services; (b) perform dental surgery; or (c) administer anesthetics for dental surgery. Dentist also includes a licensed denturist who is acting within the scope of his or her license.

SCHEDULE OF BENEFITS

[The amounts payable by this Plan for Class I, II, and III Covered Dental Benefits are described below:

Annual Deductible Per Insured Person (per Policy Year) (Waived on Class I & Dental Accident Benefits)	\$25 per Insured Person \$75 per Family
Class I - Diagnostic & Preventive (Includes care such as cleanings, X-rays,	100% of R & C (Deductible waived)

and exams)	
Class II - Restorative, Oral Surgery, Periodontics & Endodontics (Includes care such as fillings and extractions)	80% of R & C
Class III - Major Restorative & Prosthodontics (Includes care such as crowns and dentures)	50% of R & C
Dental Maximum Per Insured Person (per Policy Year)	\$1,000 per Insured person]

COVERAGE

ACCIDENTAL DENTAL INJURY: Means this Plan will pay {100%} of Expenses, up to the {\$1,000} Dental Maximum, arising as a direct result of an accidental bodily Injury. However, payment for accidental Injury claims will not exceed the unused program Dental Maximum. The accidental bodily Injury must have occurred while the Insured Person was eligible. An accidental bodily Injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the Accident.

BENEFIT FOR COVERED EXPENSES: Means amounts payable shown in the Schedule of Benefits. We will not pay benefits for any amounts used to satisfy a Deductible and the total amount payable will not exceed the Dental Maximum Benefit.

DEDUCTIBLE AND MAXIMUM AMOUNTS: The Deductible and the Dental Maximum will be applied each Policy Year to Covered Expenses as outlined in the Schedule of Benefits. Such Expenses must be incurred during the Accumulation Period.

ALTERNATE TREATMENT: If more than one type of service can be used to treat a condition, We have the right to base benefits on the least expensive service which is within the range of professionally adequate standards of dental practice. In the case of a bilateral multiple adjacent missing teeth, the benefit amount will be based on a removable partial denture. [Treatment must begin within {30} days of the Injury and all services must be provided within {12} months of the date of Injury.]

[PREDETERMINATION OF BENEFITS: A dental treatment plan should be submitted to {XXXX} prior to any course of dental treatment which will exceed {\$200} in cost. The Dentist may use a standard dental claim form. The Company will notify the Insured Person and his or her Dentist of what benefits will be paid. If the Insured Person and his or her Dentist agree to a higher charge, the Company will not pay the excess charge.

If a dental treatment plan is not filed in advance, the Company will pay benefits as if a plan had been filed. Alternate courses of treatment will be considered. The Company and its professional dental advisors will decide what benefits will be paid.]

OTHER CONTRACT PROVISIONS: All other provisions and conditions of this Policy that are not directly conflicting with this provision shall apply hereto. In the provisions relating to first and third party payments and Coordination of Benefits, the term "medical" shall for the purposes of this provision include the term "dental," and the term "provider" shall include "Dentist."

INSURING CLAUSE: We will pay benefits for Covered Expenses incurred by an Insured Person subject to:

- (a) The applicable provisions and limitations of the Policy;
- (b) Expense incurred while covered under the Policy; and
- (c) The Deductible, if any.

Payment will be made according to the payment of claim provisions.

COVERED DENTAL SERVICES

[The following Preventive and Diagnostic services are covered at {100%} of the Reasonable and Customary Expenses:]

CLASS I BENEFITS

DIAGNOSTIC

Covered Dental Benefits:

1. Routine examination;
2. X-rays;
3. Emergency examination; and
4. Examination by a specialist in an American Dental Association recognized specialty.

Limitations:

1. Examination is covered two times per Policy Year;
2. Complete series (4 bitewing x-rays and up to 10 periapical x-rays) or panorex x-rays are covered once every 3-year period;
3. Supplementary bitewing x-rays are covered once every 6-month period.

Exclusions:

1. Diagnostic services and x-rays related to temporomandibular joints (jaw joints);
2. Consultations;
3. Study models;
4. Caries susceptibility tests.

PREVENTIVE

Covered Dental Benefits:

1. Prophylaxis (cleaning [, scaling and polishing]);
2. Fissure sealants;
3. Topical application of fluoride;
4. Space maintainers when used to maintain space for eruption of permanent teeth [for children under age 12; and]
- [5. Oral hygiene instruction]

Limitations:

1. Prophylaxis is covered two times every Policy Year;
2. Topical application of fluoride is covered two times every Policy Year [when performed in conjunction with a prophylaxis,] through age 18;
3. Fissure sealants are available only for Dependent children through age 13. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars

with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once every 3-year period per tooth [; and]

- [4. Oral hygiene instruction is covered for three sessions per lifetime.]

Exclusions:

- 1. Plaque control program;
- [2. Oral hygiene instruction, dietary instruction and home fluoride kits;]
- 3. Cleaning of a prosthetic appliance; and
- 4. Replacement of a space maintainer previously paid for by the Company.

CLASS II BENEFITS

RESTORATIVE

Covered Dental Benefits:

- 1. Amalgam, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp); and
- 2. Stainless steel crowns.

Limitations:

- 1. Restorations on the same surface(s) of the same tooth are covered once every 2-year period;
- 2. If a composite or filled resin restoration is placed on a posterior tooth, an amalgam allowance will be made for such procedure. The difference in cost is your responsibility; and
- 3. Stainless steel crowns are covered once every 2-year period.
- 4. Refer to Class III Limitations if teeth are restored with crowns, inlays or onlays

Exclusions:

- 1. Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion; and
- 2. Overhang removal, re-contouring or polishing of restoration.

ORAL SURGERY

Covered Dental Benefits:

- 1. Removal of teeth and surgical extractions, preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures and treatment of pathological conditions and traumatic facial injuries; and
- 2. General anesthesia/intravenous sedation.

Limitations:

General anesthesia/intravenous sedation is covered only when administered by a licensed Dentist or other approved, licensed professional who meets the educational, credentialing and privileging guidelines established by appropriate state authorities in conjunction with certain covered oral surgery procedures, as determined by the Company.

Exclusions:

- 1. Iliac crest or rib grafts to alveolar ridges;
- 2. Ridge extension for insertion of dentures (vestibuloplasty); and

3. Tooth transplants.

PERIODONTICS

Covered Dental Benefits:

1. Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth;
2. Services covered include root planing, gingivectomy and limited adjustments to occlusion (8 teeth or less); and
3. General anesthesia/intravenous sedation

Limitations:

1. Root planing is covered once every 12-month period;
2. Limited occlusal adjustments are covered once every 12-month period; and
3. General anesthesia/intravenous sedation is covered only when administered by a licensed Dentist or other approved licensed professional who meets the educational, credentialing and privileging guidelines established appropriate state authorities in conjunction with certain covered oral surgery procedures, as determined by the Company.

Exclusions:

1. Nightguards and occlusal splints;
2. Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances;
3. Gingival curettage; and
4. Major (complete) occlusal adjustment.

ENDODONTICS

Covered Dental Benefits:

1. Procedures for pulpal and root canal treatment;
2. Services covered include pulp exposure treatment, pulpotomy and apicoectomy; and
3. General anesthesia/intravenous sedation.

Limitations:

1. Root canal treatment on the same tooth is covered only once every 2-year period; and
2. General anesthesia/intravenous sedation is covered only when administered by a licensed Dentist or other approved licensed professional who meets the educational, credentialing and privileging guidelines established by appropriate state authorities in conjunction with certain covered oral surgery procedures, as determined by the Company.
3. Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance

Exclusion:

Bleaching of teeth

CLASS III BENEFITS

RESTORATIVE

Covered Dental Benefits:

1. Crowns;
2. Inlays (only when used as an abutment for a fixed bridge);

3. Onlays (whether they are gold, porcelain, Company-approved gold substitute casting (except processed resin) or combinations thereof for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay); or
4. Fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or filled resins.

Limitations:

1. Crowns, inlays or onlays on the same teeth are covered once every 5-year period;
2. Inlays are a covered benefit on the same teeth once every 5-year period only when used as an abutment for a fixed bridge;
3. If a tooth can be restored with a filling material such as amalgam or filled resin, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided; or
4. The Company will allow the appropriate amount for an amalgam or composite restoration toward the cost of processed filled resin or processed composite restorations.

Exclusions:

1. A crown used as an abutment to a partial denture for purposes of re-contouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required;
2. Crowns used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology exists; and
3. Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology.

PROSTHODONTICS

Covered Dental Benefits:

Dentures, fixed bridges, removable partial dentures and the adjustment or repair of an existing prosthetic device.

Limitations:

1. Replacement of an existing prosthetic device is covered only once every 5-years and only if it is unserviceable and cannot be made serviceable;
2. **Full, immediate and overdentures** - The Company will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment;
3. **Temporary/interim dentures** - The Company will allow the amount of a relines toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial relines will be a benefit after 12 months;
4. **Root canal treatment** performed in conjunction with overdentures is limited to 2 teeth per arch and is paid at the Class III level;
5. **Partial dentures** - If a more elaborate or precision device is used to restore the case, the Company will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided;
6. **Denture adjustments and relines** - Denture adjustments and relines done more than 6 months after the initial placement are covered, except as noted under temporary/interim dentures. Subsequent relines and jump rebases, but not both, will be covered once every 12-month period; and

7. **Implants** - The Company will allow the appropriate amount for a standard crown, bridge, partial denture or full denture toward the cost of appliances constructed on implants. Such allowance will be paid at the Class III payment level. Any additional cost is the Insured Person's responsibility. The Company will not pay for any replacement placed within 5 years from the date of placement

Exclusions:

1. Duplicate dentures;
2. Personalized dentures;
3. Surgical placement or removal of implants or attachments to implants; and
4. Crowns and copings in conjunction with overdentures.

A charge for any dental care, treatment service or supply is considered to be incurred on the date the applicable care, treatment, service or supply is received by the Insured Person, not when it is billed.

LIMITATIONS

If a service is not specifically stated in the Schedule of Benefits, the Company will determine whether it is a covered benefit and what allowance, if any, will be provided. Benefits will be provided for the least costly procedure to restore health and function when alternative techniques of treatment are available. Limitations relating to specific services are described in the Schedule of Benefits.

EXCLUSIONS

No benefits will be provided under this provision for the following:

- [1. All other services not specifically included in this Policy as covered dental benefits;]
- [2. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections or prescription drugs;]
- [3. Application of desensitizing agents;]
- [4. Benefits payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance when such Policy or insurance is issued to or makes benefits available to the patient, whether or not application is made for such benefits. Reimbursement to the Company will be made without reduction for any attorney's fees incurred;]
- [5. Broken appointments;]
- [6. Completing insurance forms;]
- [7. Dentistry for cosmetic reasons;]
- [8. General anesthesia/intravenous (deep) sedation, except as specified by this Policy for certain oral, periodontal or endodontic surgical procedures;]
- [9. Habit breaking appliances or orthodontic services or supplies;]
- [10. Hospitalization charges and any additional fees charged by the Dentist for hospital treatment;]
- [11. In the event an Insured Person fails to obtain a required examination from a Company-appointed consultant Dentist for certain treatments, no benefits shall be provided for such treatment;]
- [12. Patient management problems;]

- [13. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth;]
- [14. Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, services which are provided to the Insured Person by any federal, state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, or any other state, under 42 U.S.C., Section 1396a section 1902 of the Social Security Act;]
- [15. Services or supplies that are experimental, which are defined as those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, the Company, in conjunction with the American Dental Association, will consider if: 1) the services are in general use in the dental community in this state; 2) the services are under continued scientific testing and research; 3) the services show a demonstrable benefit for a particular dental condition; and 4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request;]
- [16. Behavior management;]
- [17. Charges by any person other than a licensed Dentist or licensed Denturist, except for a licensed hygienist;].
- [18. Charges for any service in excess of the percentages and maximums listed in the Schedule of Benefits;]
- [19. Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements;]
- [20. Charges that would not have been made or that the Insured Person would have had no obligation to pay in the absence of this Policy;]
- [21. Local anesthesia, sterilization, and supplies billed as separate charges (these services and items are included in allowance for procedure);]
- [22. Materials not approved by the American Dental Association;]
- [23. Prescription Drugs, medications, or supplies;]
- [24. Services, supplies, or charges excluded under the Exclusions provisions of this Policy, unless specifically provided by this provision;]
- [25. Services to the extent that they are not recommended and approved by the licensed Dentist attending the Insured Person; charges above the Reasonable and Customary Expenses as determined by the Company; charges for failure to keep scheduled appointments or for filling out claim forms;]
- [26. Study and diagnostic models; or].
- [27. Services for Temporomandibular Joint Disorders.]

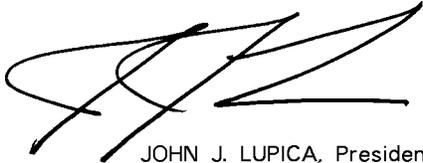
CLAIMS PROCEDURES. We shall have the right, before paying a claim, to have the Insured Person examined at the Our expense by a Dentist selected by the Company for the purpose of reviewing the extent of the work for which claim has been made and the reasonableness of the charge therefor. The Company shall have the right to request additional information from the Dentist needed to process the claim, including x-rays. No benefits will be provided unless the requested information is received. All claims must be submitted within 90 days of the date of service.

AUTHORIZATION FOR DENTAL INFORMATION. As a condition of receiving benefits under this rider, the Insured Person authorizes the Dentist to disclose or submit to the Company any dental

information or dental x-rays that it may request in order to determine the appropriate benefit payment. Failure to submit the requested information will result in either payment of an optional, less costly treatment or in denial of benefits.

This rider takes effect and expires concurrently with the Policy to which it is attached and is subject to the terms and conditions of the Policy.

For ACE Property and Casualty Insurance Company



JOHN J. LUPICA, President



CARMINE A. GIGANTI, Secretary



POLICY AMENDMENT

The rider is attached to and made part of Policy No. {NUH0123456} issued by ACE Property and Casualty Insurance Company to {ABC University}.

Effective {January 1, 20XX}, the Policy as issued is amended as follows:

VISION CARE EXPENSE BENEFIT RIDER

[Benefits under this Rider are available only to Insured Dependent children]

ELIGIBILITY

To be eligible for the vision benefits of this Policy, the Insured Student and his or her Dependents must also be covered under the medical portion of this Policy.

DEFINITIONS

Copayment - means the dollar amount an Insured Person is required to pay, if any, when a Service is rendered or Materials are purchased.

Materials - means lenses, frame, low vision aids and contact lenses.

Necessary - means that a Service rendered or Materials furnished are necessary and appropriate for the Insured Person based on generally accepted current practice. A Service or supply will not be considered Necessary if: a) provided only as a convenience to the Insured Person or provider; or b) not appropriate for the diagnosis or symptoms.

Orthoptics - means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Service - means an examination, Material selection, fitting of glasses, related adjustments, etc.

Scheduled Amount - means the maximum amount We will pay for a given Service or Material.

ELIGIBLE EXPENSES

We will pay for Eligible Expenses incurred by an Insured Person while covered under this Policy for the following Services and Materials:

A. SERVICES:

Vision Examinations - Each Insured Person is entitled to a complete analysis of the eyes and related structures to determine vision problems and other abnormalities. We will

cover such Service once every {12} months. Where the vision examination shows new lenses or frames or both are Necessary for proper visual health, such Materials will be covered, together with certain Services as Necessary.

B. MATERIALS:

1. **BASIC LENSES** (per lens) - We will pay for a new prescription for Standard Lens, if required by a change in prescription, once every {12} months. This includes single vision, bifocal, trifocal or lenticular. The lens allowance is for two lenses. If only one lens is needed, the allowance will be 1/2 the lens allowance.
2. **FRAMES** - We will pay for new Standard Frames once every {24} months.
3. **CONTACT LENSES** - When an Insured Person chooses contact lenses, We will pay for contact lenses, if required once every {12} months. Payment will be IN LIEU OF ALL OTHER MATERIALS BENEFITS.

Contact Lenses (Necessary)

The Vision Plan furnishes contact lenses for the following conditions:

- (a) following cataract surgery;
- (b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- (c) under certain conditions of Anisometropia; and
- (d) keratoconus.

Contact Lenses (Cosmetic)

The Vision Plan furnishes cosmetic contact lenses in lieu of spectacle lenses and a frame.

B. WHAT IS COVERED:

After the applicable Copayment [and Deductible, if any], We will cover charges for Services and supplies, up to the Scheduled Amount, shown below:

Vision Benefits	
EXAMINATION Once every 12 months	\$10 Copayment, then covered 100% up to \$60 maximum
FRAMES Once every 24 months	\$25 Copayment (combined w/lenses), then covered 100% up to \$70 maximum
BASIC LENSES Once every 12 months Single Vision Bifocal Trifocal Lenticular	\$25 Copayment (combined w/frames), (per lens) covered 100% up to \$50 maximum covered 100% up to \$70 maximum covered 100% up to \$90 maximum covered 100% up to \$135 maximum
CONTACTS (in lieu of lenses and frames) Once every 12 months	\$25 Copayment, then

Necessary	covered 100% up to \$250 per pair
Cosmetic	covered 100% up to \$105 per pair

THE SCHEDULED AMOUNTS SHOWN ARE MAXIMUMS. THE ACTUAL AMOUNT TO BE PAID FOR ANY SERVICE OR MATERIAL WILL BE THE LESSER OF THE SCHEDULED AMOUNT FOR SUCH SERVICE RENDERED AND/OR MATERIALS PURCHASED, OR THE ACTUAL AMOUNT CHARGED.

THERE IS NO ASSURANCE THAT THE SCHEDULED AMOUNT WILL BE SUFFICIENT TO PAY THE FULL COST OF THE SERVICE RENDERED OR THE MATERIALS SELECTED.

LIMITATIONS: In no event will payment exceed the lesser of:

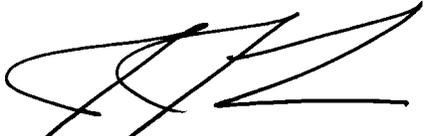
1. the actual cost of covered Services or Materials; or
2. the limits of the Policy, shown in this Schedule.

EXCLUSIONS: In addition to the Exclusions shown in the medical portion of this Policy, We will not cover:

- [1. Orthoptic or vision training and any associated supplemental testing.]
- [2. Plano lenses.]
- [3. Lens Coatings.]
- [4. Two pair of glasses, in lieu of bifocals or trifocals.]
- [5. Medical or surgical treatment of the eyes.]
- [6. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.]
- [7. Any Injury or Sickness when covered under any Workers' Compensation or similar law, or which is work-related.]
- [8. No-line bifocal or progressive lenses.]
- [9. Photo-chromatic lenses.]
- [10. Sub-normal vision aids or non-prescription lenses.]
- [11. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - (a) the Insured Person resides in the U.S. or Canada; and
 - (b) the charges are incurred while on a business or pleasure trip.]
- [12. Eyeglasses when the change in prescription is less than .5 Diopter.]
- [13. Charges in excess of the Reasonable and Customary Expense for the Service or Materials.]
- [14. Charges incurred after:
 - (a) the Policy ends; or
 - (b) the Insured Person's coverage under the Policy ends, except as stated in the Policy.]
- [15. Experimental or non-conventional treatment or device.]
- [16. Spectacle lens treatments or "add-ons", except solid tints (#1 & #2), and oversize lenses.]
- [17. High Index lenses of any material type.]
- [18. Lost or broken Materials, except when replaced at normal intervals when Services are available.]

This rider takes effect and expires concurrently with the Policy to which it is attached and is subject to the terms and conditions of the Policy.

ACE Property and Casualty Insurance Company



JOHN J. LUPICA, President



CARMINE A. GIGANTI, Secretary

SERFF Tracking Number: ACEH-127967934 State: Arkansas
 Filing Company: ACE Property and Casualty Insurance Company State Tracking Number:
 Company Tracking Number: STUDENT ACCIDENT & SICKNESS
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Student Accident & Sickness
 Project Name/Number: Student Accident & Sickness/Student Accident & Sickness

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Readability Certification is attached.</p> <p>Attachment: AR Readability Certification.pdf</p>	Approved-Closed	01/11/2012

	Item Status:	Status Date:
<p>Satisfied - Item: Application</p> <p>Comments: The Application is attached under the Form Schedule.</p>	Approved-Closed	01/11/2012

	Item Status:	Status Date:
<p>Satisfied - Item: PPACA Uniform Compliance Summary</p> <p>Comments: PPACA Uniform Compliance Summary is attached.</p> <p>Attachment: NAIC PPACA Filing Summary_AR.pdf</p>	Approved-Closed	01/11/2012

	Item Status:	Status Date:
<p>Satisfied - Item: Description of Variability</p> <p>Comments: Description of Variability is attached.</p> <p>Attachment: Description of Variable Language AH-29564-AR et al.pdf</p>	Approved-Closed	01/11/2012

	Item Status:	Status
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SERFF Tracking Number: ACEH-127967934 State: Arkansas
Filing Company: ACE Property and Casualty Insurance Company State Tracking Number:
Company Tracking Number: STUDENT ACCIDENT & SICKNESS
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Student Accident & Sickness
Project Name/Number: Student Accident & Sickness/Student Accident & Sickness

Satisfied - Item: Cover Letter

Approved-Closed

Date:

01/11/2012

Comments:

Cover Letter is attached.

Attachment:

AR Cover Letter.pdf

ACE Property and Casualty Insurance Company

436 Walnut Street
Philadelphia, Pennsylvania 19106

READABILITY CERTIFICATION SCHEDULE OF FORMS

I hereby certify that the following forms were tested for readability using the Rudolf-Flesch Formula and achieved the following results.

January 5, 2012

Student Accident and Sickness Policy	AH-29564-AR
Master Application	AH-29565
Policy Amendment Rider	AH-29566
Dental Expense Benefit Rider	AH-29567
Vision Care Expense Benefit Rider	AH-29568

<u>Form Number</u>	<u>Description</u>	<u>Score</u>
AH-29564-AR	Policy	52.3
AH-29565	Application	N/A
AH-29566	Amendment	50.0
AH-29567	Rider	51.2
AH-29568	Rider	50.9



JOHN J. LUPICA, President

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)
- SMALL / LARGE GROUP HEALTH BENEFIT PLANS** (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
ACE Property and Casualty Insurance Company	0626-20699	ACEH-127967934	AH-29564-AR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H04	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: The Pre-Existing Condition limitation does not apply to enrollees under age 19.			
	Page Number: Policy, Pg. 23			
H04	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: The Aggregate Maximum Benefit amounts reflect the requirements of PPACA.			
	Page Number: Policy, Pg. 3 and 9			
H04	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: The Aggregate Maximum Benefit amounts reflect the requirements of PPACA.			
	Page Number: Policy, Pg. 3 and 9			
H04	Prohibit Rescissions - Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: In no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.			
	Page Number: Policy, Pg 22			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H04	Preventive Services - Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Preventive Services are provided.			
	Page Number: Policy, Pg 7-13			
H04	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Dependents are covered until age 26.			
	Page Number: Policy, Pg. 17			
H04	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: The Appeals Process is included.			
	Page Number: Policy, Pg. 61			
H04	Emergency Services - Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Emergency Services are covered.			
	Page Number: Policy, Pg. 29			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H04	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Pediatricians are treated as any other provider.			
	Page Number: Policy, Pg. 18			
H04	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Providers who specialize in obstetrics or gynecology are treated as any other provider.			
	Page Number: Policy, Pg. 18			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services Explanation: Page Number:	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇ Explanation: Page Number:	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes ◇ <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number:	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.



ACE Property and Casualty
Insurance Company
(A Stock Company)
Philadelphia, PA 19106

Student Accident & Sickness Policy

STUDENT ACCIDENT & SICKNESS POLICY

AH-29564-AR, et al.

Description of Variable Language

Please note variable information is contained in soft brackets ({ }). Information which will be included or excluded is contained in hard brackets ([]). In no event will the information contained in these brackets be less favorable to an insured than the minimum standards set forth in your law.

We intend to market the Student Accident & Sickness Policy to colleges and universities for the benefit of students who are enrolled on a full or part-time basis with such institutions. Therefore, the description of eligible class may vary based on the nature of the school and the classes covered. References to members of a group throughout the forms may vary accordingly, i.e., student, dependent, member, etc.

I. Master Application – AH-29565-AR

The Master Application contains variable material set forth in brackets. All bracketed material within this form is illustrative material. Illustrative material consists of any entries such as names, dates, addresses, classes eligible, benefit amounts, benefit periods, ages, numbers, amounts, percentages or time periods which may be omitted or revised as applicable to a policyholder's plan.

The bracketed references will be appropriately modified to reflect grammatical form.

II. Policy – AH-29564-AR

The Policy contains variable material set forth in brackets. All bracketed material within the form is illustrative material. Illustrative material consists of any entries such as names, dates, addresses, classes eligible, benefit amounts, benefit periods, ages, numbers, amounts, percentages or time periods which may be omitted or revised as applicable to a Policyholder's plan. Variations will occur based on the nature of the group, the classes covered, the benefits offered and the applicability of certain provision at either the case, class or benefit level.

Ranges (e.g., of days, amounts, percentages) are shown for some illustrative material. Actual entries will always fall within the ranges.

Coverage will be offered on either a non-contributory, contributory or voluntary basis. As such, the text used will vary based on premium sources, method of enrollment and the plans available.

The filing contains a Policy Amendment form (form #). All of the benefits and provisions that apply to a Policyholder will be included in the Policy and Certificate text when first issued. We will issue the amendment form if there are any changes in the plan of benefits or provisions after the initial effective date.

The bracketed references will be appropriately modified to reflect grammatical form.

Specific, variable material is noted below. Specific variable material will be changed only as indicated in

the explanations shown below. But illustrative material that appears within specific variable material may be varied as described above.

1. Each bracketed Definition may be included as shown, modified as indicated by brackets, or omitted as applicable to a Policyholder's plan. Placement of definitions may vary to allow definitions to be moved to the benefit provisions to which they apply or form benefit provisions to the Definitions section.
2. Each bracketed Benefit may be included as shown, modified as indicated by brackets, or omitted as applicable to a Policyholder's plan.
3. Each bracketed Limitation or Exclusion may be included as shown, modified as indicated by brackets, or omitted in its entirety or in part as applicable to a Policyholder's plan.
4. Any wording that solely relates to the rights and obligations of the Policyholder may be omitted.
5. "You", "Your", or "Yours" may be substituted for "Insured/Covered Person" and personal pronouns may be omitted.
6. Connective words and phrases that only serve the grammatical purpose of meaningful continuity and do not reflect the description of or the payment of benefits or other substantive terms or conditions of the policy affecting the insurance provided may vary. These variations will occur as required to ensure the readability of the forms where other variable material; is changed. These wording changes will not be ambiguous or deceptive.
7. The order and grouping of provisions may be modified. References to information contained in the certificate schedule may be expressed in the text of the provision as it relates to a particular class of Insureds.
8. The print size style, page size and layout may be modified to reflect various formats including 8.5 X 11 pages, booklet pages or brochure styles subject to the print and other requirements of your readability law.
9. Specific rates may be omitted or replaced with reference to rates currently in force.
10. The inclusion of certain provisions and their wording may vary to meet the specifications of the product requested by our customers or to clarify the administration of the policy or other items as requested by our customers.
11. Wording may be changed to comply with future changes in your laws or regulations impacting the policy, or with the laws of the states where the policy are delivered. For example, if a state requires disclosure that the policy is issued in another jurisdiction, or requires inclusion of certain mandated benefits or provisions for residents of their state covered under the policy.

III. Policy Amendment – AH-29566

This rider is for administrative amendments to in force plans, to allow changes such as to rates or benefits that may be revised as applicable to a particular plan. Only approved policy language will be used on this form.

The following are examples of administrative amendments that may be used on this form:

Effective {**January 1, 20XX**}, this Policy and Certificate as issued is amended as follows:

- [1]. Changing the **POLICY NUMBER** to: **54321**
- [2]. Changing the **POLICYHOLDER** to: **XYZ Company**
- [3]. Changing the **POLICY EFFECTIVE DATE** to: **January 1, 20XX**
- [4]. Changing the **POLICY TERMINATION DATE** to: **January 1, 20XX**
- [5]. Changing the **SCHEDULE OF PREMIUM RATES** as follows:

<u>CLASS OF INSURED PERSONS</u>	<u>TERM OF COVERAGE</u>	<u>PREMIUM RATE</u>
<u>January 1, 20XX – January 1, 20XX</u>		
Student	Annual	\$XX.XX

IV. Dental Expense Benefit Rider – AH-29567; Vision Care Expense Benefit Rider – AH-29568

These Riders may be used to provide benefits to all Insured Persons under the Policy or benefits under these Riders may be limited to only Insured Dependent children.

These Riders contain variable material set forth in brackets. All bracketed material within the forms is illustrative material. Illustrative material consists of any entries such as names, dates, addresses, classes eligible, benefit amounts, benefit periods, ages, numbers, amounts, percentages or time periods which may be omitted or revised as applicable to a Policyholder's plan. Variations will occur based on the nature of the group, the classes covered, the benefits offered and the applicability of certain provision at either the case, class or benefit level.

The bracketed references will be appropriately modified to reflect grammatical form.

Specific, variable material is noted below. Specific variable material will be changed only as indicated in the explanations shown below. But illustrative material that appears within specific variable material may be varied as described above.

1. Each bracketed Definition may be included as shown, modified as indicated by brackets, or omitted as applicable to a Policyholder's plan. Placement of definitions may vary to allow definitions to be moved to the benefit provisions to which they apply or form benefit provisions to the Definitions section.
2. Each bracketed Benefit may be included as shown, modified as indicated by brackets, or omitted as applicable to a Policyholder's plan.
3. Each bracketed Limitation or Exclusion may be included as shown, modified as indicated by brackets, or omitted in its entirety or in part as applicable to a Policyholder's plan.
4. Any wording that solely relates to the rights and obligations of the Policyholder may be omitted.
5. "You", "Your", or "Yours" may be substituted for "Insured/Covered Person" and personal pronouns may be omitted.
6. Connective words and phrases that only serve the grammatical purpose of meaningful continuity and do not reflect the description of or the payment of benefits or other substantive terms or conditions of the policy affecting the insurance provided may vary. These variations will occur as required to ensure the readability of the forms where other variable material; is changed. These wording changes will not be ambiguous or deceptive.
7. The order and grouping of provisions may be modified. References to information contained in the certificate schedule may be expressed in the text of the provision as it relates to a particular class of Insureds.
8. The print size style, page size and layout may be modified to reflect various formats including 8.5 X 11 pages, booklet pages or brochure styles subject to the print and other requirements of your readability law.
9. Specific rates may be omitted or replaced with reference to rates currently in force.
10. The inclusion of certain provisions and their wording may vary to meet the specifications of the product requested by our customers or to clarify the administration of the policy or other items as requested by our customers.
11. Wording may be changed to comply with future changes in your laws or regulations impacting the policy, or with the laws of the states where the policy are delivered. For example, if a state requires disclosure that the policy is issued in another jurisdiction, or requires inclusion of

certain mandated benefits or provisions for residents of their state covered under the policy.



ace usa

ACE USA
ACE USA Accident & Health
Division
Routing WA09D
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Philadelphia, PA 19106

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Andrew Mead
Director of Compliance

January 10, 2012

Insurance Commissioner Jay Bradford
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201

Re: ACE Property and Casualty Insurance Company - NAIC Number 0626-20699
Student Accident and Sickness Insurance Policy
Policy Form AH-29564-AR, et al.

Dear Commissioner Bradford:

We respectfully submit the forms listed below for filing on behalf of ACE Property and Casualty Insurance Company for your review and approval. These forms are new and not intended to replace any forms currently on file. Pennsylvania, our domiciliary state, does not require the filing of forms intended for issue outside of the state. The following forms are enclosed:

<u>Form Name</u>	<u>Form Number</u>
Student Accident and Sickness Policy	AH-29564-AR
Master Application	AH-29565
Policy Amendment Rider	AH-29566
Dental Expense Benefit Rider	AH-29567
Vision Care Expense Benefit Rider	AH-29568

Student Accident & Sickness Insurance Policy (AH-29564-AR) is designed to provide coverage on a blanket basis to students attending an educational institution. Coverage may also be extended to the dependents and spouses of students. This enclosed Student Accident and Sickness Policy and related forms and riders are intended to comply with the Patient Protection and Affordable Care Act (PPACA) of 2010.

The variable material in these forms has been indicated by brackets. Highlighted "Filing Notes" are embedded within the forms to provide explanations of variability. A Description of Variable Language is also enclosed.



ace usa

We appreciate the advice previously given by the Department in preparation of this filing. If there are any questions or if additional information is required, please feel free to contact me at (732) 945-2320 or email Andrew.Mead@Combined.com. If it would facilitate your review, I would be happy to arrange a conference call, or at your discretion, a meeting to discuss any questions you may have.

Very truly yours,

A handwritten signature in cursive script that reads "Andrew Mead".

Andrew Mead
Director of Compliance

SERFF Tracking Number: ACEH-127967934 State: Arkansas
 Filing Company: ACE Property and Casualty Insurance Company State Tracking Number:
 Company Tracking Number: STUDENT ACCIDENT & SICKNESS
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Student Accident & Sickness
 Project Name/Number: Student Accident & Sickness/Student Accident & Sickness

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/10/2012	Form	Student Accident & Sickness Policy	01/10/2012	PPACA Policy AH-29564-AR.pdf (Superseded)



ACE Property and Casualty
Insurance Company
(A Stock Company)
Philadelphia, PA 19106

Student Accident & Sickness Policy

ACE Property and Casualty Insurance Company agrees to provide the benefits shown in the Plan of Insurance with respect to each person insured for them under this Policy. The benefits will be paid in accordance with the provisions of this Policy.

This Policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums as set forth herein.

This Policy takes effect as of 12:01 a.m., {Eastern Standard} Time, on its Policy Effective Date. This Policy ends as of 12:01 a.m., {Eastern Standard} Time, on its Policy Termination Date. These dates are shown in the Plan of Insurance.

The provisions on the pages which follow form a part of this Policy. This Policy is issued at the Administrative Office of ACE Property and Casualty Insurance Company on {January 1, 20XX}.

This Insurance Policy Number {CUH0123456} is issued to {ABC University}.
(the Policyholder)

For ACE Property and Casualty Insurance Company



JOHN J. LUPICA, President



CARMINE A. GIGANTI, Secretary

Your student health insurance coverage, offered by ACE Property and Casualty Insurance Company, may not meet the minimum standards required by title XXVII of the Public Health Services Act. Specifically, the coverage will not be renewed when you are no longer a student at {ABC University}; and the restrictions on annual dollar limits on your benefits may not be the same as other types of coverage. For policy years beginning before September 23, 2012, if a policy for student health insurance coverage applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$100,000. Your student health insurance coverage put an annual limit of {\$100,000 to unlimited} on “Essential Benefits” described in this Policy. If you have any questions or concerns about this notice, contact {1-800-352-4462.}

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[SECTION I - PLAN OF INSURANCE

{Filing Note: The Plan of Insurance is completely optional and variable. Benefits provided will be based on case-specific information, and will never be less than permissible under state laws.}

PPO PLAN DESIGN

Policyholder: {ABC University}
Policy Number: {CUH12345}
Policy Effective Date: {January 1, 20XX}
Policy Termination Date: {January 1, 20XX}

{Filing Note: The minimum Policy Aggregate Maximum Benefit for Essential Benefits will reflect the requirements of the Patient Protection and Affordable Care Act as shown below, which may be adjusted in accordance with changes in state or federal regulatory requirements:}

*Policy effective date prior to September 23, 2012: \$100,000
Policy effective dates September 23, 2012 through December 31, 2013: \$2,000,000
Policy effective dates January 1, 2014 and later: Unlimited*

Copayments may apply to one or more of the benefits listed below; limitations on the number of treatments covered for one or more of the benefits listed below may be included, (not applicable to Preventive Services).}

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil".

Policy Aggregate Maximum Benefit:

(for Essential Benefits only)

Per Insured Person: {\$100,000 - Unlimited}

{Filing Note: Plans will not impose deductibles, copayments or other forms of cost sharing that exceed the limits required by the Patient Protection and Affordable Care Act.}

Deductible per Policy Year (Not applicable to Preventive Services):

Network Provider: {\$100.00 - \$1,000} per Insured Person

Non-Network Provider: {\$100.00 - \$1,000} per Insured Person

Out-of-Pocket Maximum per Policy Year:

Network Provider: {\$1,000 - \$5,000} per Insured Person

Non-Network Provider: {\$1,000 - \$5,000} per Insured Person

COVERAGE

BENEFIT AMOUNT

ESSENTIAL BENEFITS:

HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Miscellaneous Hospital Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Surgery Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Multiple Surgical Procedure Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Anesthesia Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Assistant Surgeon Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

OUTPATIENT EXPENSE BENEFIT

Doctor's Office Visit Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Chiropractic Care Office Visit Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Hospital Outpatient Department Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Emergency Room Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{90% of R & C}
Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Radiation Therapy and Intravenous Chemotherapy Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Physical Therapy Expense Covered Percentage:	

Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Occupational Therapy Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Speech Therapy Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
High Cost Procedures Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

MENTAL OR NERVOUS DISORDERS EXPENSE BENEFIT

Inpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Outpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

ALCOHOL OR DRUG DEPENDENCY EXPENSE BENEFIT

Inpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}
Outpatient Expense Covered Percentage:	
Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

MATERNITY EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

AMBULANCE EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{90% of R & C}

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
Non-Network Provider:	{70% of R & C}

LICENSED NURSE EXPENSE BENEFIT

Covered Percentage: Network Provider:	{90% of the Preferred Allowance}
---------------------------------------	----------------------------------

Non-Network Provider: {70% of R & C}

HOSPICE EXPENSE BENEFIT

Covered Percentage: Network Provider: {80% of R & C}
Non-Network Provider: {80% of R & C}

PRESCRIPTION DRUG EXPENSE BENEFIT

Copayment: Generic Drugs: {\$10.00 per prescription}
Brand Name Drugs
[Generic Not Available]: {\$15.00 per prescription}
Brand Name Drugs
[Generic Available]: {\$20.00 per prescription}

PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

SKILLED NURSING FACILITY EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

DIABETES EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

ENTERAL FOOD FORMULA EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

HEARING AIDS EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

OSTOMY EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

ASTHMA EDUCATION EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

MORBID OBESITY EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

DENTAL CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Dental Care Expense Benefit Rider

VISION CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Vision Care Expense Benefit Rider

CLINICAL TRIALS EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

PREVENTIVE SERVICES

(Covered charges for Preventive Services do not apply to the Policy Aggregate Maximum for Essential Benefits)

PREVENTIVE SERVICES FOR ADULTS EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

PREVENTIVE SERVICES FOR WOMEN EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

PREVENTIVE SERVICES FOR CHILDREN EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

MANDATED BENEFITS

CHILDREN'S PREVENTIVE HEALTH CARE EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

IN VITRO FERTILIZATION EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }
Benefit Maximum {\$15,000 per lifetime}

PHENYLKETONURIA EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

SPEECH OR HEARING LOSS OR IMPAIRMENT EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

Benefit Maximum for Hearing Aids

[Hearing Aid benefit not subject to Deductible or Copayment]:

[\$1,400 per ear for each 3-year period]

MUSCULOSKELETAL DISORDERS IN FACE, NECK OR HEAD EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C }

GENERAL ANESTHESIA FOR DENTAL CARE EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

PROSTATE CANCER SCREENING EXPENSE BENEFIT

Covered Percentage: Network Provider: {100% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

{OPTIONAL BENEFIT PROVISIONS

(Covered charges for Optional Benefit Provisions do not apply to the Policy Aggregate Maximum for Essential Benefits)

ABORTION EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum {\$5,000 - \$50,000}

PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

STUDENT HEALTH CENTER REFERRAL

Included

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT – Per Accident [or Per Sickness]

Covered Percentage: {100% of actual Expense}
Benefit Maximum: {\$5,000 - \$50,000}

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage: {100% of actual Expense}
Benefit Maximum: {\$5,000 - \$50,000}

CONSULTANT EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

SICKNESS DENTAL EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}}

ALLERGY TESTING AND TREATMENT EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}
Non-Network Provider: {70% of R & C}

Benefit Maximum: {\$100 - \$2,000 per Policy Year}

PODIATRIC EXPENSE BENEFIT

Covered Percentage: Network Provider: {90% of the Preferred Allowance}

Non-Network Provider: {70% of R & C}

Benefit Maximum: {\$100 - \$2,000 per Policy Year}

[SECTION I - PLAN OF INSURANCE

{Filing Note: The Plan of Insurance is completely optional and variable. Benefits provided will be based on case-specific information, and will never be less than permissible under state laws.}

INDEMNITY PLAN DESIGN

Policyholder: {ABC University}
Policy Number: {CUH12345}
Policy Effective Date: {January 1, 20XX}
Policy Termination Date: {January 1, 20XX}

{Filing Note: The minimum Policy Aggregate Maximum Benefit for Essential Benefits will reflect the requirements of the Patient Protection and Affordable Care Act as shown below, which may be adjusted in accordance with changes in state or federal regulatory requirements:}

*Policy effective date prior to September 23, 2012: \$100,000
Policy effective dates September 23, 2012 through December 31, 2013: \$2,000,000
Policy effective dates January 1, 2014 and later: Unlimited*

Copayments may apply to one or more of the benefits listed below; limitations on the number of treatments covered for one or more of the benefits listed below may be included, (not applicable to Preventive Services).}

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil".

Policy Aggregate Maximum Benefit:

(for Essential Benefits only)

Per Insured Person: {\$100,000 – Unlimited}

{Filing Note: Plans will not impose deductibles, copayments or other forms of cost sharing that exceed the limits required by the Patient Protection and Affordable Care Act.}

Deductible per Policy Year:

(Not applicable to Preventive Services)

[\$100.00 - \$1,000] per Insured Person

Out-of-Pocket Maximum per Policy Year:

{\$1,000 - \$5,000} per Insured Person

COVERAGE

BENEFIT AMOUNT

ESSENTIAL BENEFITS:

HOSPITAL EXPENSE BENEFIT

Hospital Room & Board Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Miscellaneous Hospital Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

Surgery Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Multiple Surgical Procedure Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Anesthesia Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Assistant Surgeon Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

OUTPATIENT EXPENSE BENEFIT

Doctor's Office Visit Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Chiropractic Care Office Visit Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Hospital Outpatient Department Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Emergency Room Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Diagnostic X-ray and Laboratory Testing Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Radiation Therapy and Intravenous Chemotherapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Physical Therapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Occupational Therapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Speech Therapy Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

High Cost Procedures Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

MENTAL OR NERVOUS DISORDERS EXPENSE BENEFIT

Inpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Outpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

ALCOHOL OR DRUG DEPENDENCY EXPENSE BENEFIT

Inpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

Outpatient Expense Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

MATERNITY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

AMBULANCE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

LICENSED NURSE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

HOSPICE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000 then 80% of R & C}

PRESCRIPTION DRUG EXPENSE BENEFIT

Copayment: Generic Drugs: {\$10.00 per prescription}
 Brand Name Drugs
 [Generic Not Available]: {\$15.00 per prescription}
 Brand Name Drugs
 [Generic Available]: {\$20.00 per prescription}

PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

SKILLED NURSING FACILITY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

DIABETES EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

ENTERAL FOOD FORMULA EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

HEARING AIDS EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

OSTOMY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

ASTHMA EDUCATION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

MORBID OBESITY EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
 then 80% of R & C}

DENTAL CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Dental Care Expense Benefit
 Rider

VISION CARE EXPENSE BENEFIT RIDER

Benefit Maximum: See Vision Care Expense Benefit
 Rider

CLINICAL TRIALS EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}

PREVENTIVE SERVICES

(Covered charges for Preventive Services do not apply to the Policy Aggregate Maximum for Essential Benefits)

PREVENTIVE SERVICES FOR ADULTS EXPENSE BENEFIT

Covered Percentage: {100% of R & C}

PREVENTIVE SERVICES FOR WOMEN EXPENSE BENEFIT

Covered Percentage: {100% of R & C}

PREVENTIVE SERVICES FOR CHILDREN EXPENSE BENEFIT

Covered Percentage: {100% of R & C}

MANDATED BENEFITS

CHILDREN'S PREVENTIVE HEALTH CARE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}

IN VITRO FERTILIZATION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}
Benefit Maximum {\$15,000 per lifetime}

PHENYLKETONURIA EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}

SPEECH OR HEARING LOSS OR IMPAIRMENT EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}

Benefit Maximum for Hearing Aids
[Hearing Aid benefit not subject to Deductible
or Copayment]: {\$1,400 per ear for each 3-year
period}

MUSCULOSKELETAL DISORDERS IN FACE, NECK OR HEAD EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}

GENERAL ANESTHESIA FOR DENTAL CARE EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}

PROSTATE CANCER SCREENING EXPENSE BENEFIT

{100% of R & C up to the first \$5,000
then 80% of R & C}

{OPTIONAL BENEFIT PROVISIONS

(Covered charges for Optional Benefit Provisions do not apply to the Policy Aggregate Maximum for Essential Benefits)

ABORTION EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum {\$5,000 - \$50,000}

PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage: {100% of R & C up to the first \$5,000
then 80% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

STUDENT HEALTH CENTER REFERRAL

Included

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT – Per Accident [or Per Sickness]

Covered Percentage: 100% of actual Expense
Benefit Maximum: {\$5,000 - \$50,000}

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage: 100% of actual Expense
Benefit Maximum: {\$5,000 - \$50,000}

CONSULTANT EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$500 - \$2,000 per Policy Year}

SICKNESS DENTAL EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}}

ALLERGY TESTING AND TREATMENT EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}

PODIATRIC EXPENSE BENEFIT

Covered Percentage: {90% of R & C}
Benefit Maximum: {\$100 - \$2,000 per Policy Year}

SECTION II - SCHEDULE OF ELIGIBLE CLASSES

<u>CLASS</u>	<u>DESCRIPTION OF CLASS</u>
{ I.	All full-time students of the Policyholder who are enrolled for 12 credit hours or more per semester.
II.	Dependents of Insured Students, as defined in the Definitions Section of this Policy.}

SECTION III - SCHEDULE OF PREMIUM RATES

<u>CLASS OF INSURED PERSONS</u>	<u>TERM OF COVERAGE</u>	<u>PREMIUM RATE</u>
[Student Only	Annual	\$()
Spouse Only	Annual	\$()
Child(ren) Only	Annual	\$()
Student Only	Spring	\$()
Spouse Only	Spring	\$()
Child(ren) Only	Spring	\$()
Student Only	Summer	\$()
Spouse Only	Summer	\$()
Child(ren) Only	Summer	\$()]

SECTION IV - DEFINITIONS

{Filing Note: Definitions may vary based on the plan of benefits elected by the policyholder. They may appear here, in a general section, or elsewhere in the document as the terms are used.}

Whenever used in this Policy:

“Accident” means a specific unforeseen, unintended and unexpected event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

["Allowed Application Period" means a period of {15} days after the Policy Effective Date or for those students who start mid year, {15} days from the start of the {quarter} during which an eligible student may enroll and be covered as of the Policy Effective Date or the start of the {quarter}, respectively.]

"Coinsurance" means the percentage of Covered Charge or Expenses for which the Insured Person is responsible for a covered service.

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

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

Not included are: (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.]

["Copayment" means the specified dollar amount an Insured Person must pay for specified charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.]

“Covered Charge” or “Expense” as used herein means those charges for any treatment, services or supplies that are: [(a)] for Network Providers, not in excess of the Preferred Allowance; [(b)] [for Non-Network Providers,] not in excess of the Reasonable and Customary Expenses; [(c)] not in excess of the charges that would have been made in the absence of this insurance; and [(d)] incurred while this Policy is in force as to the Insured Person [except with respect to any expense payable under the Extension of Benefits].

[For purposes of the Extension of Benefits, if an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the {30} day period following such termination of insurance.]

"Covered Percentage" means that part of the Covered Charge that is payable by the Company after the Deductible or Copayment has been met.

"Custodial Care" means services and supplies, including room and board charges, which are furnished mainly to help a person meet his or her routine daily needs and can be furnished by someone who has no professional health care training.

["Deductible" means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.]

["Dependent" means: (a) the Insured Student's spouse [residing with the Insured Student] [or Domestic Partner residing with the Insured Student]; or (b) the Insured Student's Children under the age of {26 – 30} years. Coverage for newborn children will consist of coverage for Accident or Sickness, including:

- (a) necessary care or treatment of congenital defects;
- (b) birth abnormalities;
- (c) premature birth;
- (d) tests for hypothyroidism, phenylketonuria and galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants mandated by law;
- (e) routine nursery care; and
- (f) routine pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time].

Such coverage will start from the moment of birth. In the event additional premium is required for such child then the coverage will terminate 90 days from the date of birth unless written request to continue insurance is made to Us and the premium is paid within 90 days from the date of birth or before the next premium due date, whichever is later.

In the case of minor children under the Insured Student's charge, care and control for whom the Insured Student has filed a petition to adopt, coverage will be effective:

- (a) From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
- (b) On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage will be to the same extent as specified above. Any additional premium required for such child must be paid at the time application is made.

The term "children" includes an Insured Student's biological children; step-children; and adopted children.

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

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

[Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.]]

"Doctor" as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

[**"Domestic Partner"** means the [same][opposite] sex partner of an Insured Student who has filed a "Declaration of Domestic Partnership" with the Policyholder's administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.]

[**"Domestic Student"** is a student classified as a United States Citizen and a student classified by the United States Government as a Permanent Resident.]

"Effective Date" means the first date a student becomes covered under the Policy.

"Elective Treatment" means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

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

[**"Experimental or Investigational Care"** means a service or supply:

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

The advice of medical consultants and commonly recognized national medical organizations may be relied upon in determining which services or supplies are experimental or investigational.]

"Hospital" means a facility which meets all of these tests:

- (a) it provides inpatient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it operates and is licensed as a Hospital under the laws of the jurisdiction in which it is located.

Hospital does not include a place that operates mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

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

"Injury" means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

"Insured Person" means an Insured Student [and his or her covered Dependent(s)] while insured under this Policy.

"Insured Student" means a student of the Policyholder who is eligible and insured for coverage under this Policy.

["International Student" is a student classified by the United States Government as a Non-Immigrant holding an F-1, J-1, or M-1 Non-Immigrant Visa.]

"Loss" means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

"Medical Emergency" means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

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

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

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

["Network Providers" are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.]

["Non-Network Providers" have not agreed to any pre-arranged fee schedules.]

"Out-of-Pocket Maximum" means the maximum dollar amount an Insured Person is responsible to pay during a Policy Year. After an Insured Person has reached the Out-of-Pocket Maximum, We cover most benefits at 100% for the remainder of the Policy Year. Some benefits, however, will remain payable at the percentage shown in the Plan of Insurance. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Copayments. Penalties and amounts above the Reasonable and Customary Expense do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown in the Plan of Insurance.]

"Policy Aggregate Maximum" means for each Insured Person, the maximum amount of benefits payable for all Injuries and Sicknesses combined under the Student Health Insurance Policy each Policy Year.

"Policy Effective Date" means the date the Policy takes effect as shown in the Plan of Insurance.

"Policyholder" means the institution indicated on the face page of this Policy.

["Policy Termination Date" means the date the Policy ends as shown in the Plan of Insurance.]

"Policy Year" means the 12 month period beginning on the Policy Effective Date.

["Preferred Allowance" means the amount a Network Provider will accept as payment in full for Covered Charges.]

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

"Sickness" means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

"We", "Us" and "Our" mean ACE Property and Casualty Insurance Company.

"You" and "Your" mean the Insured Student.

SECTION V - EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL

This Policy takes effect as of the Policy Effective Date stated in the Plan of Insurance. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided in the General Provisions Section, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on the first anniversary of the Policy Effective Date or any date thereafter. We will give the Policyholder at least {sixty days} prior written notice. [We also reserve the right to refuse to renew this Policy.]

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

SECTION VI- EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE

EFFECTIVE DATE OF INSURED PERSON'S COVERAGE

The insurance of each Eligible Student shall take effect as follows:

- [(a) If an Eligible Student enrolls [and pays the premium] on or before the Policy Effective Date, coverage will begin on the Policy Effective date;]
- [(b) If an Eligible Student enrolls [and pays the premium] after the Policy Effective Date but within the Allowed Application Period, coverage will begin on the Policy Effective Date or the start of the term or semester in which the student has enrolled;]
- [(c) If an Eligible Student enrolls [and pays the premium] after the Allowed Application Period, coverage will begin on the day after the enrollment card [and premium] is received; or]
- [(d) If an Eligible Student enrolls [and pays the premium] on or before the Policy Effective Date and such student is a participant in intercollegiate sports or a school sponsored activity or requirement, coverage will begin on the date the eligible student is required to be on campus.]]

{Filing Note: The following Text may be included if dependent coverage is provided.}

[LATE ENROLLMENT FOR DEPENDENTS

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

- [(a) when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester [or pro-rated premium] is required even if the spouse is enrolled after the term has begun;]
- [(b) when he or she provides a signed affidavit of Domestic Partnership. Proof of Domestic Partnership may be required. Payment for the full semester [or pro-rated premium] is required even if the Domestic Partner is enrolled after the term has begun;]
- [(c) when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application must be submitted and coverage will be effective as specified in the definition of "Dependent". Payment for the full semester [or pro-rated premium] is required even if the Dependent child is enrolled after the term has begun; and]
- [(d) when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's

arrival following direct travel from the homeland. Payment for the full semester [or pro-rated premium] is required even if the Dependent is enrolled after the term has begun.;

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

TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates:

- [(a) on the date this Policy is terminated;] or
- [(b) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error;] or
- [(c) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person;] or
- [(d) on the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes;] or
- [(e) on the last day the Insured Student is required to be on campus at the Policyholder or, if the Policyholder has so elected, the anniversary of the Policyholder's Policy.]]

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

{Filing Note: The following Text may be included if it applies to the plan.}

[If a student loses eligibility under this Policy because he or she no longer qualifies under the terms described in the Master Policy, he or she may apply for continuation of coverage. The application must be made within 31 days of losing eligibility, and the applicable premium must be paid.]

SECTION VII – RENEWABILITY OF COVERAGE

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

[SECTION VIII - PRE-EXISTING CONDITIONS LIMITATION

(Not applicable to Insured Persons under age 19)

{Filing Note: Policies effective January 1, 2014 and later will not include Pre-existing Condition limitation}

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

The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student's effective date, and (b) We will pay only for Loss or expense incurred after such twelve (12) consecutive month period.

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

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

The Pre-existing Condition Waiting Period will not apply:

- (a) To pregnancy.
- (b) In the case of an Insured Person who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage.
- (c) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured Person held Creditable Coverage, and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

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

Definition

"Creditable Coverage" means health benefits or coverage provided to a person pursuant to:

- (a) A group health plan;
- (b) Health insurance coverage;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Sec. 1928 of that Title;
- (e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, Chapter 55 of title 10, U.S.C.;
- (f) A medical care program of the Indian Health Service or of a tribal organization;
- (g) A State health benefit risk pool;
- (h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, under chapter 89 of title 5, U.S.C.;
- (i) A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
- (j) A health benefit plan under Sec. 5(e) of the Peace Corps Act, 22 U.S.C. Sec. 2504(e).]

{Filing Note: The following Text may be included if it applies to the plan.}

[SECTION IX - CONTINUOUS INSURANCE

This Policy may be replacing a Prior Plan with another insurer.

Prior Plan means (a) the Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy; and (b) other policies providing Creditable Coverage as defined in this Policy.

"Injury" or "Sickness" shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the Policy Aggregate Maximum.

Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.]

SECTION X - COVERAGE

All benefits to this Policy are shown in the Plan of Insurance. The benefits are described on the pages attached to and made a part of this Policy.

ACCIDENT EXPENSE BENEFIT

When, by reason of Injury, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance. Benefits are paid in accordance with the schedule shown in the Plan of Insurance. When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth as a result of the Accident, We will pay for the Covered Percentage of the Covered Charges incurred, as shown in the Plan of Insurance. The Accident must have occurred while coverage under the Policy is in force as to the Insured Person incurring the expense. Charges applicable to this provision incurred during the continuation of coverage shall also be included in the term "Expense" but only while they are incurred.

What We pay is shown in the Plan of Insurance.

SICKNESS EXPENSE BENEFIT

When, by reason of Sickness, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay for the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance. The date of the first medical treatment for the Sickness must have occurred while coverage under this Policy is in force as to the Insured Person incurring the expenses. Charges applicable to this provision incurred during the continuation of coverage shall also be included in the term "Expense" but only while they are incurred.

What We pay is shown in the Plan of Insurance.

Charges that are not covered for Accident & Sickness Expense Benefits

Charges to buy or rent:

- Air conditioners;
- Air purifiers;
- [Motorized transportation equipment;]
- Escalators or elevators in private homes;
- Eye glass frames or lenses;
- Swimming pools or supplies for them;
- General exercise equipment.

HOSPITAL EXPENSE BENEFIT

Part A Hospital Room and Board Expense

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

Part B Miscellaneous Hospital Expense

{Filing Note: Covered expenses may vary at the request of the Policyholder, subject to the minimum standards of your state.}

Miscellaneous Hospital Expense includes expenses incurred for:

- (a) [anesthesia, anesthesia supplies and services;]
- (b) [operating, delivery and treatment rooms and equipment;]
- (c) [diagnostic x-ray and laboratory tests;]
- (d) [lab studies;]
- (e) [oxygen tent;]
- (f) [blood and blood services;]
- (g) [prescribed drugs and medicines;]
- (h) [medical and surgical dressings, supplies, casts and splints;]
- (i) [radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;]
- (j) [chemotherapy treatment with radioactive substances;]
- (k) [intravenous injections and solutions, and their administration;]
- (l) [physical and occupational therapy; and]
- (m) [other necessary and prescribed Hospital expenses.]

We will pay the Covered Percentage of the Covered Charge incurred by the Insured Person during the period of Hospital Confinement for which benefits are payable under Part A, Hospital Room and Board Expense above.

What We pay is shown in the Plan of Insurance.

SURGICAL EXPENSE BENEFIT

Part A Surgery Expense Benefit

When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Charges of the Surgical Expense, in connection with any one Surgical Procedure, subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Definitions

"Surgical Expense" means charges by a Doctor for:

- (a) a Surgical Procedure;
- (b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and
- (c) usual post-operative treatment.

"Surgical Procedure" means:

- (a) a cutting procedure;
- (b) suturing of a wound;

- (c) treatment of a fracture;
- (d) reduction of a dislocation;
- (e) radiotherapy;
- (f) electrocauterization;
- (g) diagnostic and therapeutic endoscopic procedures;
- (h) injection treatment for hemorrhoids and varicose veins;
- (i) an operation by means of a laser beam.

Part B Multiple Surgical Procedures Expense Benefit

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

Part C Anesthesia Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the Expenses incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

[Part D Assistant Surgeon Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the Expense incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[Part E Second Surgical Opinion Expense Benefit

We will also provide benefits to an Insured Person for a second opinion consultation by a board certified specialist on the need for non-emergency surgery which has been recommended by the Insured Person's Doctor. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any required x-rays and diagnostic tests done in connection with that consultation.

We will pay the Covered Charges incurred by the Insured Person as shown in the Plan of Insurance. [Any Deductible or Coinsurance is waived for Expenses incurred in connection with the Second Surgical Opinion.]

What We pay is shown in the Plan of Insurance.]

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Percentage of the Covered Charge incurred for such services, subject to the Deductible shown in the Plan of Insurance.

{Filing Note: Covered expenses may vary at the request of the Policyholder, subject to the minimum standards of your state.}

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

- [(a) one Doctor visit per day;]
- [(b) constant care and treatment while an Insured Person is confined in an intensive care unit;]
- [(c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors;]
- [(d) consultation by another Doctor when requested by the Insured Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.]]

What We pay is shown in the Plan of Insurance.

OUTPATIENT EXPENSE BENEFIT

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

What We pay is shown in the Plan of Insurance.

Outpatient Services

{Filing Note: Covered expenses may vary at the request of the Policyholder, subject to the minimum standards of your state.}

Covered Charges for "Outpatient Services" include the following services:

- (a) [a Doctor's office while not Hospital Confined;]
- (b) [chiropractic care up to the maximum shown in the Plan of Insurance;]
- (c) [a Hospital outpatient department or emergency room;]
- (d) [diagnostic x-ray and laboratory testing;]
- (e) [blood and blood services, if provided and billed by a Hospital or other facility;]
- (f) [physical and occupational therapy as shown in the Plan of Insurance;]
- (g) [radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;]
- (h) [radiological lab or other similar facility licensed by the state;]
- (i) [surgical dressings, splints, casts, and other devices used to correct fractures and dislocations;]
- (j) [speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment. Speech therapy must be in keeping with a Doctor's written order for type, frequency, and duration;]
- (k) [shots and injections when received in the Doctor's office.]

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

{Filing Note: This text may be excluded}

[High Cost Procedures

High Cost Procedures, as used herein, means an outpatient procedure costing over [\$200.00.]

Covered Charges for High Cost Procedures include, but are not limited to, charges for the following procedures and services:

- (a) [C.A.T. Scan;]
- (b) [Magnetic resonance imaging; and]
- (c) [Laser treatment.]

The covered percentage for High Cost Procedures is shown in the Plan of Insurance.

If, by reason of similar benefit provision elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.]

MENTAL OR NERVOUS DISORDERS EXPENSE BENEFIT

We will pay the Covered Percentage of Covered Charges incurred for Medically Necessary treatment of Mental or Nervous Disorders.

Benefits for such treatment will be paid as they would for any other Sickness, subject to the following:

- (a) Inpatient confinement including partial hospitalization must be in a Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Services, Division of Mental Health Services. Partial hospitalization means continuous treatment for at least 4 hours but not less than 16 hours in any 24 hour period.
- (b) Outpatient benefits will be provided for services furnished by a:
 - (1) Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Service, Division of Mental Health Services;
 - (2) Doctor licensed under the Medical Practices Act;
 - (3) licensed psychologist; or
 - (4) community mental health center or other mental health clinic certified by the Department of Human Service, Division of Mental Health Services.

What We pay is shown in the Plan of Insurance.

Definition

“Mental or Nervous Disorders”

This term means those conditions listed in the standard nomenclature of the American Psychiatric Association.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[ALCOHOL OR DRUG DEPENDENCY EXPENSE BENEFIT

We will pay the Covered Percentage of Covered Charges incurred for the Medically Necessary treatment for an Insured Person with Alcohol or Drug Dependency in a Hospital or an Alcohol and Drug Dependency Treatment Center.

Benefits for such treatment will be paid as they would for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

"Alcohol and Drug Dependency Treatment Center" is a public or private facility or unit of a facility engaged in providing 24 hour treatment for substance abuse, and which provides a program for treatment of such abuse pursuant to a written treatment plan approved and monitored by a Doctor, properly licensed or accredited by the Department of Human Services/Office on Alcohol and Drug Abuse Prevention. The facility or unit may be: a) within a Hospital or psychiatric hospital or attached to or be a freestanding unit of a general Hospital or psychiatric hospital; or b) a freestanding facility specializing in such treatment, but it does not include halfway houses or recovery farms.

"Alcohol or Drug Dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.]

MATERNITY EXPENSE BENEFIT

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

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

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

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

Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine

procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

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

Covered Charges also include Doctor prescribed pre-natal vitamins.

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

What We pay is shown in the Plan of Insurance.

AMBULANCE EXPENSE BENEFIT

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

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

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

What We pay is shown in the Plan of Insurance.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such Durable Medical Equipment, subject to the Deductible shown in the Plan of Insurance. We pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is our property and is to be returned to Us, at Our expense, upon completion of the Insured Person's need, if so requested by Us.

What We pay is shown in the Plan of Insurance.

Definition

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

HOME HEALTH CARE EXPENSE BENEFIT

We will cover charges for Home Health Care services furnished to an Insured Person. Such benefits must be provided by a licensed Home Health Agency.

What We pay is shown in the Plan of Insurance.

Definitions

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

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

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

LICENSED NURSE EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

HOSPICE EXPENSE BENEFIT

If an Insured Person is Terminally Ill and requires a coordinated plan of home and inpatient care, We will cover charges for hospice services furnished to the Insured Person on the same basis as any other Sickness. The services must be under active management through a licensed hospice and approved by Us.

Covered Services will include:

- (a) part-time intermittent home nursing care by or under the direction of a graduate Registered Nurse;
- (b) medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill Insured Person.
- (c) counseling, including dietary counseling, for the Terminally Ill Insured Person;

- (d) Family Counseling for the immediate family and the family caregiver before the death of the Terminally Ill Insured Person;
- (e) Bereavement Counseling for the immediate family or family caregiver of the Insured for at least the 6 month period following the Insured Person's death or 15 visits, whichever occurs first.

What We pay is shown in the Plan of Insurance.

Definitions

“Terminally Ill” means a medical prognosis given by a Doctor that the Insured Person's life expectancy is 6 months or less.

“Bereavement Counseling” means counseling provided to the immediate family or family caregiver of the insured after the Insured Person's death to help the immediate family or family caregiver cope with the death of the Insured Person.

“Family Counseling” means counseling given to the immediate family or family caregiver of the Terminally Ill Insured Person for the purpose of learning to care for the Insured Person and to adjust to the death of the Insured Person.

PRESCRIPTION DRUG EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires drugs, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such drugs and the Medically Necessary services associated with the administration of such drugs, subject to the Copayment shown in the Plan of Insurance.

The drugs must be prescribed by a Doctor. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

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

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

What We pay is shown in the Plan of Insurance.

PROSTHETIC APPLIANCE AND ORTHOTIC DEVICE EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic Appliance or Orthotic Device, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase, initial fitting, and needed adjustment of such appliances or devices, as shown in the Plan of Insurance.

We do not pay for the replacement of Prosthetic Appliances or Orthotic Devices more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria.

What We pay is shown in the Plan of Insurance.

Definitions

“Prosthetic Appliance” means an external appliance that: (1) is intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (2) is custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

Prosthetic Appliance does not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

“Orthotic Device” means an external device that: (1) is intended to restore physiological function or cosmesis to a patient; and (2) is custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: (1) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (2) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body

What We pay is shown in the Plan of Insurance.

SKILLED NURSING FACILITY EXPENSE BENEFIT

If an Insured Person requires continuing treatment in a Skilled Nursing Facility following hospitalization, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for treatment in such Skilled Nursing Facility.

The services must be Medically Necessary as a continuation of treatment for the condition for which the Insured Person was previously hospitalized. The Insured Person must be admitted to the Skilled Nursing Facility following a Medically Necessary Hospital stay.

We cover such charges the same way We treat Covered Charges for any Hospital Confinement.

What We pay is shown in the Plan of Insurance.

Definition

“**Skilled Nursing Facility**” means a facility that is primarily engaged in providing inpatient skilled nursing care and related services to patients requiring convalescent and rehabilitative care. The facility must:

- (a) be directed by a duly licensed Doctor;
- (b) provide continuous 24 hour a day nursing service by or under the supervision of a registered graduate professional nurse (RN);
- (c) maintain a daily medical record of each patient;
- (d) be operated pursuant to law and appropriately licensed or certified;
- (e) be certified by the Medicare program.

Such facility must not include any home, facility or part thereof, used primarily:

- (a) for rest or treatment of tuberculosis;
- (b) for the aged, or for the care of drug addiction;
- (c) for the care and treatment of mental diseases or disorders, or custodial or educational care.

DIABETES EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for medical equipment, medical supplies, and diabetes self-management training solely for the management and treatment of Diabetes.

Benefits for self-management training include one per lifetime training program per Insured Person with Diabetes provided by a health care provider upon certification by such provider giving the training that the Insured Person has successfully completed the training.

In addition to the one lifetime training program provided above, additional diabetes self-management training will be covered in the event that a Doctor prescribes additional training and it is Medically Necessary because of a significant change in the Insured Person’s symptoms or conditions.

The provider or diabetes educator shall only provide diabetes self-management training within his scope of practice after having demonstrated expertise in diabetes care and treatment. The provider or diabetes educator may only provide such training after having completed an education training program required by his licensing board when such program is in compliance with the National Standards for Diabetes Self-Management Education Program, developed by the American Diabetes Association. The Doctor must issue a written prescription ordering the training for the Insured Person or his parent, spouse or legal guardian. The training must be successfully completed by the diabetic Insured Person and parent, spouse or legal guardian. The provider must certify successful completion; and provide a written certification of such to the referring Doctor and to Us. We will not pay benefits unless and until the provider provides certification that the Insured Person has successfully completed the diabetes self-management training.

The diabetes education process for self-management training must include the following standards:

- (a) Needs Assessment. The health care provider must conduct an individualized educational needs assessment with the participation of the Insured Person, family, legal guardian, or

support systems to be used in the development of the educational plan and interventions. The educational needs assessment shall include, but not be limited to, the following:

- Health history;
 - Medical history;
 - Previous use of medication;
 - Diet history;
 - Current mental health status;
 - Use of health care delivery systems;
 - Life-style practices such as occupation, education, financial status, social and cultural and religious practices, health beliefs and attitudes or preventive behaviors;
 - Physical and psychological factors including age, mobility, visual acuity, manual dexterity, alertness, attention span, and ability to concentrate;
 - Barriers to learning such as education, literacy level, perceived learning needs, motivation to learn, and attitude;
 - Family and social support; and
 - Previous diabetes education, including actual knowledge and skills.
- (b) Education Plan. The provider must develop a written education plan in collaboration with the Insured Person, his parent, spouse or legal guardian from information obtained in the needs assessment, including the following:
- Desired patient outcomes;
 - Measurable, behaviorally-stated learner objectives; and
 - Instructional methods.
- (c) Education Intervention. The provider must create an educational setting conducive to learning with adequate resources for space, teaching and audio-visual aids to facilitate the educational process. The provider must use a planned content outline. The content outline must be provided based on the needs assessment
- (d) Evaluation of Learner Outcomes. The provider must review and evaluate the degree to which the Insured Person with diabetes is able to demonstrate diabetes self-management skills as identified by behavioral objectives.
- (e) Plan for Follow-up for Continuing Learning Needs. The provider must review the educational plan and recommend any additional educational interventions to meet continuing learning needs.
- (f) Documentation. The provider must maintain written files and thereby completely and accurately document the educational experiences provided, and communicate such to the referring Doctor.

Diabetic equipment, supplies and appliances include the following which are prescribed by a Doctor as Medically Necessary for an Insured Person with Diabetes:

- (a) Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
- (b) Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
- (c) Test strips for glucose monitors, which include all test strips approved by the FDA, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
- (d) Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method of monitoring.
- (e) Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge.

- (f) Injection aids, which include devices used to assist with insulin injection;
- (g) Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
- (h) Insulin pumps as prescribed by the Doctor and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
- (i) Oral agents for controlling the blood sugar level, which are prescription drugs;
- (j) Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Diabetes Self-Management Training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalization and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

"Diabetes" means and includes Type 1, Type 2, or gestational diabetes, diabetes insipidus, and other specific types, and diabetes mellitus, a common chronic, serious systemic disorder of energy metabolism which includes a heterogeneous group of metabolic disorders which can be characterized by an elevated blood glucose level. The terms diabetes and diabetes mellitus are considered synonymous and defined to include Insured Persons using insulin and not using insulin and Insured Persons with elevated blood glucose levels induced by pregnancy, or Insured Persons with other medical conditions or medical therapies which wholly or partially consist of elevated blood glucose levels.

"Diabetes Educator or Health Care Provider" means only a person, licensed by and who has completed the Arkansas State Board's educational program that is in compliance with the National Standards for Diabetes Self-Management Educational Programs as developed by the American Diabetes Association, and only those duly certified to instruct in diabetes self-management.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[ENTERAL FOOD FORMULA EXPENSE BENEFIT

We will cover charges for non-prescription enteral formulas for home use, which are Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis,

gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[HEARING AIDS EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Hearing Aids if the Hearing Aids are prescribed, fitted, and dispensed by a licensed audiologist. An Insured Person may choose a Hearing Aid that is priced higher than the amount payable under this benefit and may pay the difference between the price of the Hearing Aid and the amount payable under this benefit, without financial or contractual penalty to the provider of the Hearing Aid.

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

What We pay is shown in the Plan of Insurance.

Definition

"Hearing Aid" means a nondisposable device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by Insured Persons.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[OSTOMY EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. "Ostomy" includes colostomy, ileostomy and urostomy.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[TEMPOROMANDIBULAR JOINT DYSFUNCTION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for any diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is Medically Necessary to treat conditions caused by congenital or developmental deformity, Injury, disease or Sickness.

Benefits are not provided for the care or treatment of the teeth or gums, for intraoral prosthetic devices, or for surgical procedures for cosmetic purposes.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[ASTHMA EDUCATION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for all medically appropriate and necessary asthma outpatient self-management training and educational services that the Insured Person's treating Doctor or other appropriately licensed health care provider, or a Doctor who specializes in the treatment of asthma, certifies are necessary for the treatment of asthma.

If certified as necessary, the asthma outpatient self-management training and educational services, to be provided to the Insured Person shall be provided through a program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes asthma education or management.

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

What We pay is shown in the Plan of Insurance.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[MORBID OBESITY EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for treatment of Morbid Obesity through gastric bypass surgery or another surgical method that is:

- (a) recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity; and
- (b) consistent with criteria approved by the National Institutes of Health.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Morbid Obesity" means a Body Mass Index that is:

- (a) greater than 40 kilograms per meter squared; or
- (b) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

"Body mass index" means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.]

{Filing Note: for policies effective prior to January 1, 2014, this benefit is optional and may be omitted if requested by the Policyholder. For policies effective January 1, 2014 or later, this benefit will be included to the extent required by state or federal laws or regulations.}

[CLINICAL TRIALS EXPENSE BENEFIT RIDER

We will pay the Covered Percentage of the Covered Charges incurred for Routine Patient Care Costs that an Insured Person receives in connection with participating in a Clinical Trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved Clinical Trial.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Clinical Trial" means:

- (1) A clinical research study or clinical investigation the purposes of the prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening illness and is approved or funded in full or in part by one or more of the following:
 - (a) The National Institutes of Health;
 - (b) The Centers for Disease Control and Prevention;
 - (c) The Agency for Health Care Research and Quality;
 - (d) The Centers for Medicare and Medicaid Services;
 - (e) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
 - (f) The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
- (2) A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or

- (3) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Routine Patient Care Costs" means:

- (1) Items, drugs, and services that are typically provided absent a clinical trial;
- (2) Items, drugs, and services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- (3) Items, drugs, and services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Routine Patient Care Costs does not include the cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection and analysis needs; or items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.]

PREVENTIVE SERVICES FOR ADULTS EXPENSE BENEFIT

We cover charges for preventive services expenses for adults. These are for services rendered to an adult Insured Person. These services are limited to the following:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50 or at high risk for colorectal cancer
 - (a) Annual fecal occult blood test or annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; or
 - (b) Double-contrast barium enema every five (5) years;
 - (c) Colonoscopy every ten (10) years
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:

- (a) Hepatitis A
 - (b) Hepatitis B
 - (c) Herpes Zoster
 - (d) Human Papillomavirus
 - (e) Influenza
 - (f) Measles, Mumps, Rubella
 - (g) Meningococcal
 - (h) Pneumococcal
 - (i) Tetanus, Diphtheria, Pertussis
 - (j) Varicella
 - (k) HPV
12. Obesity screening and counseling for all adults
 13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
 14. Tobacco Use screening for all adults and cessation interventions for tobacco users
 15. Syphilis screening for all adults at higher risk

What We pay is shown in the Plan of Insurance.

PREVENTIVE SERVICES FOR WOMEN EXPENSE BENEFIT

We cover charges for preventive services expenses for women. These are for services rendered to an woman Insured Person. These services are limited to the following:

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast Cancer Mammography screenings:
 - a. One baseline Mammogram for a woman thirty-five through thirty-nine years of age;
 - b. One Mammogram every twelve or twenty-four months for a woman forty through forty-nine years of age, inclusive, based on the recommendation of a Doctor;
 - c. One Mammogram every twelve months for a woman fifty years of age or older;
 - d. Upon recommendation of a woman's Doctor, without regard to age, where such woman has had a prior history of breast cancer or where such woman's mother or sister has had a history of breast cancer.
5. Breast Cancer Chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk

9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
16. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services for women under 65

What We pay is shown in the Plan of Insurance.

PREVENTIVE SERVICES FOR CHILDREN EXPENSE BENEFIT

We cover charges for preventive services expenses for women. These are for services rendered to an woman Insured Person. These services are limited to the following:

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood Pressure screening for children
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders
10. Fluoride Chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns

12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - (a) Diphtheria, Tetanus, Pertussis
 - (b) Haemophilus influenzae type b
 - (c) Hepatitis A
 - (d) Hepatitis B
 - (e) Human Papillomavirus
 - (f) Inactivated Poliovirus
 - (g) Influenza
 - (h) Measles, Mumps, Rubella
 - (i) Meningococcal
 - (j) Pneumococcal
 - (k) Rotavirus
 - (l) Varicella
18. HPV vaccines for children from age 7 to age 18
19. Iron supplements for children ages 6 to 12 months at risk for anemia
20. Lead screening for children at risk of exposure
21. Medical History for all children throughout development
22. Obesity screening and counseling
23. Oral Health risk assessment for young children
24. Phenylketonuria (PKU) screening for this genetic disorder in newborns
25. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
26. Tuberculin testing for children at higher risk of tuberculosis
27. Vision screening for all children

What We pay is shown in the Plan of Insurance.

[CHILDREN'S PREVENTIVE HEALTH CARE EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Periodic Preventive Care Visits, provided by or under the supervision of a single Doctor per visit, from the moment of birth through age 18 years. Periodic Preventive Care Visits include 20 visits at approximately the

following intervals: 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 Periodic Preventive Care Visits: (a) will be reimbursed at levels that will not exceed those established for the same services under the Medicaid program of the State of Arkansas; and (b) except for recommended immunization services, are subject to any applicable deductible, coinsurance and maximum amounts.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Children's Preventive Health Care" means Doctor-delivered or Doctor-supervised services for a covered Dependent child from the moment of birth through 18 years of age. Periodic Preventive Care Visits include medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

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

[IN VITRO FERTILIZATION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for in vitro fertilization services, including cryopreservation, subject to the following:

- (a) Participants must be interspousal with respect to donor and recipient; and
- (b) There must be a documented two year history of unexplained infertility; or
- (c) Infertility is associated with one or more of the following conditions:
 - (1) Endometriosis;
 - (2) DES;
 - (3) Blockage or removal of one or both fallopian tubes not a result of voluntary sterilization;
 - (4) Contributing abnormal male factors.

Expenses incurred for in vitro fertilization services are covered to the same extent and subject to the same policy provisions as any other maternity related expenses. The lifetime maximum benefit is \$15,000.

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

What We pay is shown in the Plan of Insurance.]

[PHENYLKETONURIA EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for amino acid modified preparations, Low Protein Modified Food products and formulas for therapeutic treatment of an Insured Person with phenylketonuria if:

- (a) The Medical Food or Low Protein Modified Food products are prescribed as Medically Necessary for phenylketonuria;
- (b) The products are administered under the direction of a Doctor; and
- (c) The cost of the Medical Food or Low Protein Modified Food products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year per person income tax credit allowed under Arkansas law.

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

What We pay is shown in the Plan of Insurance.

Definitions

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one gram of protein per service and intended to be used under the direction of a Doctor for the dietary treatment of an inherited metabolic disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Doctor.]

[SPEECH OR HEARING LOSS OR IMPAIRMENT EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary treatment for Loss or Impairment of Speech or Hearing.

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

What We pay is shown in the Plan of Insurance.

Definition

"Loss or Impairment of Speech or Hearing" includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his or her area of certification.]

[MUSCULOSKELETAL DISORDERS IN FACE, NECK OR HEAD EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary treatment and diagnosis of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of Accident, trauma, congenital defect, developmental defect or pathology.

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

What We pay is shown in the Plan of Insurance.]

GENERAL ANESTHESIA FOR DENTAL CARE EXPENSE BENEFIT

We will pay the expenses incurred to cover general anesthesia and associated facility charges for dental procedures rendered in a Hospital or general surgery center when the clinical status or underlying medical condition of an Insured Person requires dental procedures that ordinarily would not require anesthesia in a Hospital or surgery center setting.

This benefit applies only to general anesthesia and associated facility charges and only for the following Insured Persons:

1. Insured Persons who are under seven (7) years of age;
2. Insured Persons who are developmentally disabled, regardless of age; or
3. Insured Persons whose health is compromised or for whom general anesthesia is necessary, regardless of age.

We will not cover the charges for the dental procedure itself, including the professional fee of the dentist. Coverage for anesthesia and associated facility charges will be subject to all other terms and conditions of this Policy the same as for any other covered Injury or covered Sickness. We will not provide benefits under this provision for anesthesia or related facility charges for dental procedures that ordinarily would require general anesthesia and that do not meet the requirements of items 1, 2, or 3 of this benefit.

Coverage for general anesthesia and associated Hospital or ambulatory facility charges is restricted to dental care that is provided by:

- (a) a fully accredited specialist in pediatric dentistry;
- (b) a fully accredited specialist in oral and maxillofacial surgery; and
- (c) a dentist to whom Hospital privileges have been granted.

This benefit does not cover dental care rendered for temporomandibular joint disorders.

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

What We pay is shown in the Plan of Insurance.

PROSTATE CANCER SCREENING EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for an annual screening for the early detection of prostate cancer in men over age 40 who are covered under the policy.

Benefits shall not exceed the actual charge for such screening, subject to the maximum shown in the Plan of Insurance.

The screening must be performed by a qualified medical professional. This includes a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant. The screening will consist, at a minimum, of the following tests:

- (a) a prostate-specific antigen (PSA) blood test;
- (b) digital rectal examination.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that this benefit is not subject to any Deductible provision.

What We pay is shown in the Plan of Insurance.

{Filing Note: this benefit is optional and may be included as shown or omitted}

[ABORTION EXPENSE BENEFIT

If as a result of pregnancy an Insured Person has a voluntary abortion, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance. Expenses for the voluntary abortion must be incurred while the Policy is in force as to the Insured Person.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Principal Sum referred to in this provision is shown in the Plan of Insurance.

When, because of an Injury, the Insured Person suffers any of the following Losses within [180] days from the date of the Accident, We will pay as follows:

For Loss Of:

[Life	Principal Sum
Two hands	{One-half of Principal Sum - Principal Sum}
Two feet	{One-half of Principal Sum - Principal Sum}
Sight of two eyes	{One-half of Principal Sum - Principal Sum}
One hand and one foot.....	{One-half of Principal Sum - Principal Sum}
One hand and sight of one eye.....	{One-half of Principal Sum - Principal Sum}
One foot and sight of one eye.....	{One-half of Principal Sum - Principal Sum}
One hand or one foot or one eye.....	{One-half of Principal Sum - Principal Sum}
[Thumb and Index Finger of Either Hand{One Quarter of Principal Sum - One-half of Principal Sum}]]	

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. [Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.]

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

[This provision does not cover the Loss if it in any way results from or is caused or contributed:

- [(1) By suicide, attempted suicide, or intentionally self-inflicted injury;]
- [(2) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;
- [(3) By an infection, unless it is caused solely and independently by a covered Accident;
- [(4) [For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or]
- [(5) [While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.]

In addition to the above, this provision is subject to the Exclusions as provided.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[PRE-ADMISSION TESTS EXPENSE BENEFIT

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

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

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

This provision shall apply with respect to the Insured Person only to the extent that the Insured Person is insured under this Policy for Hospital Expense Benefits.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[STUDENT HEALTH CENTER REFERRAL

In order to obtain the maximum benefit available when medical treatment is needed, the Insured Student must go to the Student Health Center (SHC) first where treatment will be administered or a referral issued. [Such charges are subject to the Deductible.] Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained [are excluded from coverage] [will be paid at {80%} of the benefits otherwise payable under the Plan of Insurance]. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary only under the following conditions:

- (1) [Medical Emergency; (The student [and Dependent] must return to SHC for necessary follow-up care.)]
- (2) [When the Student Health Center (SHC) is closed;]
- (3) [When service is rendered at another facility during break or vacation periods;]
- (4) [Medical care received when the student is more than {50 miles} from campus;]
- (5) [Medical care obtained when a student is no longer able to use the SHC due to a change in students status;]
- (6) [Maternity;]
- (7) [Gynecological Services; or]
- (8) [Psychotherapy.]

[Dependents are not eligible to use the SHC; and therefore, are exempt from the above limitations and requirements.]]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to [Domestic Students while studying in the United States][or][Domestic Students while studying abroad outside their Home Country [and their eligible Dependents while accompanying the student],][International Students studying abroad while outside their Home Country [and their eligible Dependents while accompanying the student],]. We will pay benefits for the Covered Percentage of the Covered Charge incurred, if any Injury [or Sickness] results in the Emergency Medical Evacuation of the Insured Person.

We will pay, subject to the limitations set forth below, for Eligible Emergency Medical Evacuation Expenses reasonably incurred if the [Domestic Student,] [International Student,] [or] [his or her eligible Dependent] suffers an Injury [or Sickness] that warrants his or her Emergency Medical Evacuation. The Injury [or Sickness] must occur while the [Domestic Student [and his or her eligible Dependents while accompanying the student] [is] [are] outside a {100,150,200} mile radius from the Domestic Student's current place of primary residence] [or] [International Student [and their eligible Dependents while accompanying them] outside the International Student's Home Country]. The Emergency Medical Evacuation Benefit is subject to the Maximum Amount shown in the Schedule of Benefits for the Emergency Medical Evacuation Benefit.

We [or Our authorized representative] must authorize all Emergency Medical Evacuation expenses in advance for this benefit to be payable. We reserve the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Us [or Our authorized representative] in advance.

Definitions

"Eligible Emergency Medical Evacuation Expenses" – as used in this Benefit, means an expense that: (1) is charged for Medically Necessary Emergency Medical Evacuation services; (2) does not exceed the usual level of charges for similar treatment, services, supplies or Transportation in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

"Emergency Medical Evacuation" - as used in this Benefit, means, if warranted by the severity of the Insured Person's Injury [or Sickness]:

- (1) the Insured Person's immediate Transportation from the place where the Injury [or Sickness] is suffered to the nearest Hospital, or other medical facility where appropriate medical treatment can be obtained;
- (2) Transportation to [the Domestic Student's current place of primary residence] [or] [the International Student's Home Country] to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury [or Sickness] and being treated at a local Hospital or other medical facility, limited to one transportation for the same related Injury [or Sickness]; or

(3) both (1) and (2) above. An Emergency Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

"Home Country" means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country [declared with Us].

"Medically Necessary Emergency Medical Evacuation Service" - as used in this Benefit, means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Medical Evacuation due to the Injury [or Sickness] for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.

"Transportation" – as used in this Benefit, means moving the Insured Person by an air, land or water conveyance during an Emergency Medical Evacuation. Conveyances include, but are not limited to, air or land ambulances and private motor vehicles.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

If Injury [or Sickness] to the Insured Person results in loss of life, We will pay, subject to the limitations set forth below, for Covered Repatriation of Remains Expenses which are reasonably incurred to return his or her body to his or her current place of primary residence. The Injury [or Sickness] must occur while the Insured Person is outside a {100,150,200} mile radius from his or her [current place of primary residence] [or] [Home Country]. Repatriation of Remains Benefits are subject to the Maximum Amount allowed shown in the Schedule of Benefits.

We [or Our authorized representative] must authorize all Repatriation of Remains expenses in advance of the actual repatriation for this benefit to be payable. We reserve the right to determine the benefit payable if it was not reasonably possible to contact Us [or Our representative in advance. All determinations and payments by Us will be final and fully release and discharge Us from any further liability under this Repatriation of Remains Benefit.

Definitions

"Covered Repatriation of Remains Expense" – as used in this benefit, means expenses limited to: (1) embalming or cremation; (2) the most economical coffin or receptacle adequate for transportation of the remains; and (3) transportation of the remains by the most economical and direct conveyance and route possible.

"Home Country" means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country [declared with Us].]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[CONSULTANT EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Charges incurred.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[SICKNESS DENTAL EXPENSE BENEFIT RIDER

If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[ALLERGY TESTING AND TREATMENT EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for diagnostic testing and treatment of allergies and immunology services. Coverage includes, but is not limited to, the following:

- (1) laboratory tests;
- (2) physician office visits, including visits to administer injections;
- (3) prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and
- (4) other medically necessary supplies and services.

What We pay is shown in the Plan of Insurance.]

{Filing Note: this benefit is optional and may be included as shown or omitted}

[PODIATRIC EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for podiatric services provided on an outpatient basis following an injury.

We will not cover expenses for routine foot care, such as trimming of corns, calluses, and nails.

We cover such charges the same way We treat Covered Charges for any other Injury.

What We pay is shown in the Plan of Insurance.]

SECTION XI – EXCLUSIONS

{Filing note: Exclusions are filed as variable and may be modified at the policyholder's request based on the experience of its plan of benefits.}

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;]
2. [Pre-existing Conditions as defined in this Policy;]
3. [Nonprescription drugs or medicines unless prescribed by a Doctor;]
4. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;]
5. [Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;]
6. [Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;]
7. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]
8. [Correction of congenital defects except as specifically provided;]
9. [Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]
10. [Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy, or the Dental Care Expense Benefit Rider. This exclusion does not apply to treatment resulting from Injury to natural teeth.]
11. [Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;]
12. [Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community;]
13. [Injury or Sickness resulting from declared or undeclared war; or any act thereof;]
14. [Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;]

15. [Injury due to participation in a riot;]
16. [Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;]
17. [For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;]
18. [For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;]
19. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]
20. [Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;]
21. [Marriage, family, and group counseling;]
22. [Services or supplies primarily for educational, vocational or training purposes, except the initial visit to diagnose and determine if a medical condition is causing a learning disability;]
23. [Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury. This exclusion does not apply to any benefits specifically provided in an attached Amendatory Rider;]
24. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]
25. [Expenses for any service or supply not specified in this Policy as a covered service;]
26. [An amount of a charge in excess of the Reasonable and Customary Expense;]
27. [Elective Treatment or elective surgery, except as specifically provided;]
28. [Services not Medically Necessary;]
29. [Expenses for emergency room treatment for an Injury or Sickness not a Medical Emergency as defined in this Policy, including emergency "follow-up" visits;]
30. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;]
31. [Voluntary or elective abortion; pregnancy of a dependent child, except as specifically provided;]

32. [Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs except as noted, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery; Doctor-prescribed Viagra will be limited to six (6) tablets per month;]
33. [Medicines not taken in the dosage or the purpose prescribed by the Insured Person's Doctor;]
34. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit; pre-natal vitamins, except as specifically provided;]
35. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition, except as specifically provided;]
36. [Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;]
37. [Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;]
38. [Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;]
39. [Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;]
40. [Expense for hair replacement, wigs or wig maintenance;]
41. [Services that have already been paid by another insurance carrier, even if those services would have otherwise been covered by this Plan. Our Plan is secondary when the Insured Person is insured by more than one U.S. insurance company. However, this does not apply to the medical portion of automobile insurance;]
42. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy;]
43. [Care, treatment or supplies furnished by a program or agency funded by any government;]
44. [Hospital inpatient admissions primarily for diagnostic studies when bed care is not Medically Necessary;]
45. [Expenses for Experimental or Investigative treatments, except as specifically provided;]
46. [[Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.]

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

SECTION XII - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. The entire contract is made up of: (a) this Policy, including Your Application; and (b) the individual applications, if any, of Insured Persons. Statements made by the Policyholder or an Insured Person shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance, unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person, or to his/her beneficiary. No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidenced by endorsement on this Policy, or by amendment of this Policy signed by Us. No agent has authority to change this Policy or to waive any of its provisions.

GRACE PERIOD. A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. You shall be liable to Us for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to Us within {30 days} after the occurrence or commencement of any Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us at Our Administrative Office or to any authorized agent, with information sufficient to identify the Insured Person, shall be deemed notice to Us.

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

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

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

PAYMENT OF CLAIMS. All benefits for Loss other than death, will be paid to the Insured Student. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. It is not required that the service be rendered by a particular Hospital or person. The Insured Person must make a written request to Us before We can do this. We must receive the request no later than the time for filing proof of Loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured Student. This choice must be in writing and filed with Us. If the Insured Student has not chosen a beneficiary, or if there is no beneficiary alive when the student dies, We will pay:

- (a) his/her parents or legal guardian, if a minor;
- (b) otherwise, We will pay his/her estate.

We will pay these benefits immediately upon receipt of due written proof of such Loss.

PHYSICAL EXAMINATION. At Our own expense, We have the right to have a Doctor examine an Insured Person when and so often as We deem reasonably necessary while there is a claim

pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

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

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

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

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

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

{Filing Note: this provision is optional and may be omitted}

[PREMIUM REFUND POLICY. If an Insured Student withdraws from the university within the first {10 days} of the first semester, and has not yet submitted a claim, he or she will receive a full refund of the insurance premium. If an Insured Student withdraws from the university after {10 days} of the first semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium. If the Insured Student withdraws: (a) other than due to entering any military service; and (b) after the first {10 days} of the semester, no premium refund will be made.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.]

[The Insured Person may cancel their coverage within {10 working days} of the Effective Date of coverage by submitting a request for cancellation in writing to the university. Under no circumstances will a cancellation refund be provided if the Insured Person has filed a claim with Us.]

{Filing Note: this provision is optional and may be omitted}

[SECTION XIII - COORDINATION OF BENEFITS

This section will be used to determine an Insured Person's benefits under this Policy IF:

the Insured Person is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans,

and

the benefits that would be paid by this Policy, without this section

PLUS

the benefits that would be paid by the other Plans, without a section similar to this section
WOULD EXCEED ALLOWED EXPENSES as defined below.

DEFINITIONS:

PLAN means a plan which provides benefits or services for, or by reason of, hospital, surgical, medical, or dental care or treatment through:

1. group, blanket or franchise insurance coverage; this does not apply to blanket school accident only coverages;
2. pre-paid plans for:
 - group hospital service;
 - group medical service;
 - group practice;
 - Individual practice; and
 - any other such plans for members of a group;
3. any plan provided by:
 - labor management trusts;
 - unions;
 - employer organizations;
 - professional organization; or
 - employee benefit organizations;
4. a government program, or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. any group or group type hospital indemnity of more than \$200.00 per day;
6. Medicare (Title XVIII of the Social Security Act); and
7. any part of a state auto reparation or indemnity act (no fault insurance) with which the state permits coordination.

Plan does not include individual or family policies; individual or family subscriber contracts except as stated. Nor does it include any group or group type hospital indemnity of \$200.00 or less per day; or medical payment benefits customarily included in the traditional automobile contracts.

THIS PLAN means the medical care benefits provided by this Policy.

ALLOWED EXPENSE means an expense which is:

- necessary, reasonable and customary;
- incurred while the person (for whom the claim is made) is insured, or is entitled to benefits after insurance ends, under this Policy; and
- at least partly covered under one of the plans covering such Insured Person.

When this plan does not pay its benefits first, "Allowed Expense" will not include an expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an allowed expense and a benefit paid.

EFFECT ON BENEFITS UNDER THIS PLAN

When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a calendar year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any calendar year, the sum of all benefits to be paid to a person (by this and all other plans) equals the allowed expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

RULES TO DETERMINE WHICH PLAN PAYS FIRST

A plan, or part of one, that does not have a section similar to this section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be:

1. The plan which covers the Insured Person as an employee rather than as a full or part-time student.

Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3 or 4 will determine which plan pays first.

2. If 1 does not apply, the plan which covers the person as a full or part-time student rather than as a dependent.
3. If 1 and 2 do not apply, the plan which covers the person as a dependent of the parent whose month and date of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with custody rather than as a dependent of the parent without custody. If the parent with custody remarries:
 - the plan which covers the child as a dependent of a parent with custody will pay its benefits first;
 - the plan which covers the child as a dependent of a stepparent will pay its benefits next; and
 - the plan which covers the child as a dependent of a parent without custody will pay its benefits last.

A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.

4. If 1, 2, or 3 do not apply, the plan which has covered the insured person for the longer time rather than the shorter time.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For this section to work, We must exchange information with other plans. To do so, We may give to, or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Us the required information.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.]

SECTION XIV – APPEALS PROCEDURES

Internal Appeals:

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

External Appeals:

If the Insured person is not satisfied with the Internal Appeals determination, External Appeal for an adverse determination (involving a determination of medical necessity) may be requested. An Insured Person may apply to the External Appeals Panel to seek continued treatment during the course of External Appeal, and the External Appeal Panel may order continued treatment if substantial harm may result due to the absence of continued treatment, upon a showing proof of substantial harm.

An Insured Person may request an External Appeal by filing a request in writing, with the External Appeals Panel of your state's Department of Insurance. This must be done within four (4) months of receipt of written notice of the final adverse determination, provided, however, that no final adverse determination is necessary where the carrier has failed to comply with timelines for internal appeal process or if the insured or his or her authorized representative is requesting an expedited external appeal at the same time that he or she is requesting an expedited internal appeal.

The Insured Person may also request an expedited External Appeal by including a certification, in writing, from the Insured Person's Doctor that delay will pose a serious and immediate threat to the Insured Person's health.

{Filing Note: this provision is optional and may be omitted}

[SECTION XV - SUBROGATION AND RECOVERY RIGHTS

RIGHT TO SUBROGATION: If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Insured Person will do what ever is necessary to enable Us to exercise Our right and will do nothing after Loss to prejudice it. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

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

LIMITATION TO OUR RECOVERY RIGHTS: We may exercise Our Right to Subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under the Policy. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a responsible third party.]

SECTION XVI - EXTENSION OF BENEFITS

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense" until such Hospital Confinement ends or until the maximum benefits available under the Policy are paid, whichever occurs first.

SECTION XVII - CONSUMER INFORMATION NOTICE

The Insurance Company may be contacted at its [Administrative Office]:

ACE Property and Casualty
Insurance Company
436 Walnut Street
Philadelphia, PA 19106
1-800-123-4567]

The Insurance Agent may be contacted at:

[Joseph Agent
123 Main Street
Anytown, AR 12345
1-800-123-4567]

The State Insurance Department may be contacted at:

Arkansas Insurance Department
[1200 West Third Street
Little Rock, AR 72201-1904
1-800-282-9134]

SECTION XVIII - GUARANTY ASSOCIATION NOTICE

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which benefits could be provided out of the assets of the impaired or insolvent insurer.