LEWERMARK
Medical Benefits Plan for DePauw University Students

COVERAGE FOR STUDENTS THAT EVERYONE CAN UNDERSTAND

Making a World of Difference

Benefits for Accident and Sickness for: DEPAUW UNIVERSITY

- 100% coverage after Copayment for most expenses
- Medical evacuation benefit
- Repatriation benefits
- Coverage complies with Title IX
- Prompt claims & administrative service

Available Exclusively Through:

The Lewer Agency, Inc.
Student Insurance Plans

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Kansas City, Missouri 64171-5247
Phone 1/800-821-7710 Fax 1/816-960-7064
www.LewerMark.com

Insured By:
Trustmark Life Insurance Company

ELIGIBILITY

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

Eligible Student: An "Eligible Student" means any international and practical training student or a domestic student of the Policyholder who meets all of the following requirements:

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

For purposes of Item 1. above, eligible students taking a term or semester break (herein referred to as "term break"), annually, in accordance with school policy and while keeping coverage in force are considered Eligible Students engaged in full-time educational activities.
For schools with a two-semester term system, summer break is the designated term break. For schools with a trimester or quarter term system, any trimester or quarter can be taken as the term break, provided only one trimester or quarter is taken per academic calendar year.
The following do not count toward fulfilling the full-time status Eligibility requirement:

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

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

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

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

Eligible Dependent

1. With respect to an international and practical training student, the term "Eligible Dependent" means a dependent of an Eligible Student who has a current passport or visa; is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien in the United States; is the Eligible Student's lawful spouse or unmarried Child (natural child, step-child, adopted child or child placed for adoption under age 24, and is enrolled for coverage under the policy at the same time the Eligible Student enrolls or within 31 days of first becoming eligible. Dependent children born in the United States are also Eligible Dependents.

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

2. With respect to a domestic student, the term “Eligible Dependent" means the Eligible Student’s lawful spouse or unmarried Child (natural child, step-child, adopted child or child placed for adoption under age 24, and who is enrolled for coverage under the policy at the same time the Eligible Student enrolls or within 31 days of first becoming eligible.

3. A disabled, unmarried Child of an Insured Student is also an Eligible Dependent if all the following conditions are met:
   1. The Child became disabled before reaching age 24;
   2. The Child is incapable of self-sustaining employment because of a developmental disability or physical handicap and is chiefly dependent upon the Insured Student for support and maintenance;
   3. The student remains insured under the Policy;
   4. The Child's premium, if any, continue to be paid;
   5. Within 31 days of the Child reaching age 24, the Insured Student furnishes to the Company, a statement of disability. The Company's approval of such statement is required for the Child to continue eligibility; and
   6. The Insured Student provides proof satisfactory to the Company of the Child's disability and dependent status when requested by the Company. Such proof shall be without cost to the Company. The Company will not ask for proof more often than once a year after the two-year period following the Child's attainment of age 24.

EFFECTIVE DATE OF INDIVIDUAL COVERAGE

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

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

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

A student covered under Extended Coverage may request that coverage be extended for an additional 30 days provided:
1. the request is made prior to the termination of extended coverage;
2. premium is promptly paid for the additional 30 days of coverage; and
3. the Insured Student and covered dependents, if any, remain in the country in which the student attended school.

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

1. the date the Eligible Student's coverage begins with respect to each Eligible Dependent the student has at time of his/her enrollment;
2. the date of birth, adoption or Placement For Adoption, if enrollment is made within 31 days of such event;
3. on the first day of the first month following the dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured Student is covered under the Policy;
4. on the first day an Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss;
5. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Dependent or after an Eligible Dependent suffers an involuntary loss of other coverage; or
6. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

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

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

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

MEDICAL EXPENSE BENEFITS

Each Insured Student covered under the international Policy has a Major Medical Benefit maximum per Accident or Sickness of $250,000. In no event will the benefit maximum for all Accidents and Sickness exceed $250,000 in any consecutive 12-month period.

Each Eligible Dependent covered under the international Policy has a Major Medical Benefit maximum per Accident or Sickness of $100,000. In no event will the benefit maximum for all Accidents and Sickness exceed $100,000 in any consecutive 12-month period.

Copayments and Coinsurance
A Copayment will be applied to Covered Expenses as follows:

1. For charges from a Physician, Covered Expenses will be paid at:
   a. 100% without application of a Copayment for services provided to an Insured Student at a Student Health Center;
   b. 100% after the Insured Individual pays a $15 Copayment per visit for services provided by a Participating Provider;
   c. 80% after the Insured Individual pays a $15 Copayment per visit for services provided by a Physician who is not a Participating Provider.
2. For charges incurred at a Hospital (including inpatient and outpatient services), Covered Expenses will be paid at:
   a. 100% after the Insured Individual pays a $50 Copayment per admission for services provided by a Participating Provider;
   b. 80% after the Insured Individual pays a $50 Copayment per admission for services provided by a Hospital which is not a Participating Provider.
3. For charges incurred at a Hospital for emergency room care, Covered Expenses will be paid at:
   a. 100% after the Insured Individual pays a $50** Copayment per admission for services provided by a Participating Provider;
   b. 80%* after the Insured Individual pays a $50** Copayment per admission for services provided by a Hospital which is not a Participating Provider.

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

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

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

INSURING CLAUSE

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

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

Out-of-Pocket Expense Maximum
When $2,000 in Out-of-Pocket Expenses has been paid by an Insured Individual during a calendar year, the 80% level of benefit payments, if otherwise applicable when a provider who is not a Participating Provider is used will automatically increase to 100% for additional Covered Expenses incurred by that Insured Individual during the remainder of that calendar year, and Copayment charges will no longer apply. An Out-of-Pocket Expense is the 20% share of any otherwise Covered Expense and Copayment amounts which an Insured Individual pays when a provider who is not a Participating Provider is used.
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Medical Benefits

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

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

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

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

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

   NOTICE: The policy will not cover rental charges for equipment in excess of the purchase price of the equipment;
9. charges for treatment of diabetes and diabetic self-management training;
10. charges for well-child care at the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years and the charges may not be applied to the deductible;
11. charges for one routine baseline or screening mammogram in any consecutive 12-month period for women age 18 and over or more frequently based on a Doctor's recommendation;
12. charges for one routine pap smear in any consecutive 12-month period for women age 18 and over or more frequently based on a Doctor's recommendation;
13. charges for prescription oral contraceptives dispensed by a Student Health Center or a licensed pharmacist; the Policy will pay up to 50%;

14. charges for newborn examinations for the detection of phenylketonuria; hypothyroidism; hemoglobinopathies, including sickle cell anemia; galactosemia; maple syrup urine disease, homocystinuria; inborn errors of metabolism that result in mental retardation; congenital adrenal hyperplasia; biotinidase deficiency; and disorders detected by tandem mass spectrometry or other technologies.
15. charges for an infant physiologic hearing examination, at the earliest feasible time for the detection of hearing impairments.
16. charges for testing newborns to detect HIV, if a Physician believes that testing the newborn is Medically Necessary.
17. charges for off-label use of prescription drugs for the treatment of cancer. "Off label use" means the use of a drug for indications other than those stated in the labeling approved by the federal Food and Drug Administration.
18. charges for treatment of a pervasive developmental (psycho/neurological) disorder (such as Asperger's syndrome and autism) which includes all treatment prescribed in a Physician's treatment plan regardless of any Policy exclusion or limitation to the contrary.

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

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

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

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

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

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

Newborn Infants - Well Baby Care: A newborn Child of an Insured Student will be an Insured Individual from the moment of birth if: (1) notice of the birth of the Child is provided to the Company within 31 days from the date of the birth, and (2) the required payment of the appropriate premium, if any, is received by the Company. Covered expenses for the newborn Child will include: (a) Hospital room and board (or nursery) charges, (b) routine Doctor visits while Hospital confined; and (c) circumcision while Hospital confined. Such covered expenses for Well Baby Care are payable until the earlier of the date the Child is discharged from the Hospital or the date the Child is 7 days old.

Coverage for an Adopted Child: A newly adopted Child or Child Placed for Adoption with the Insured Student will automatically be covered for 31 days from the earlier of:

1. the date of placement for adoption; or
2. the date of the entry of a court order granting the Insured Student custody of the Child for purposes of adoption.

Coverage will be the same as for any other eligible Child. A newly adopted Child enrolled within this 31 day period is not subject to the Policy's pre-existing Limitation.

In order to continue the coverage beyond the 31st day when coverage began: (1) notice must be provided to the Company within 31 days from the date of the adoption or placement for adoption; and (2) the required payment of the appropriate premium, if any, must be received by the Company. If (1) and (2) above are not satisfied, coverage, including any Continuation of Benefits, will terminate 31 days after the coverage becomes effective.

Post-Mastectomy Coverage
Coverage of a Medically Necessary mastectomy will also include coverage of the following:
1. physical complications during any stage of the mastectomy, including lymphedemas;
2. reconstruction of the breast;
3. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
4. two external breast prostheses.

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

Mental and Nervous Disorders/Substance Abuse
Benefits will be paid for inpatient treatment of a Mental or Nervous Disorder or Drug Dependency up to an aggregate limit of 30 days of inpatient care in any consecutive 12-month period. Outpatient treatment of a mental or nervous disorder will be paid subject to a maximum number of 10 outpatient visits in any consecutive 12-month period.

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

Medical Evacuation Benefit
Subject to prior approval from the Company or its authorized administrator, as an additional benefit the policy will cover, up to a maximum benefit of $50,000 of reasonable charges for air evacuation of an injured or sick Insured Individua**l** and a Health Care Provider or Escort if directed by the attending Physician, to the individual's Home City home country or country of regular domicile, provided air evacuation:
(1) is upon the attending Physician's written certification;
(2) results from a covered Injury or Bodily Infirmity; and
(3) does not occur prior to the benefit approval..

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

Continuation Benefits
Covered expenses incurred, while hospital confined, will be payable up to a maximum benefit of $5,000 or 13 weeks, whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's insurance terminates.

Such benefits terminate if the Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

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

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

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

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

1. Insured Student. The plan which covers the person as an Insured Student is primary. If an Insured Individual is also covered by Medicare, the plan covering the person as an Insured Student is primary, the plan covering the person as a dependent of an Insured Student is secondary, and then Medicare.

2. Dependent Children.

    a. If the parents are not separated or divorced, the plan which covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan which covered the parent longer is primary. If the other plan does not follow the "birthday rule", the other plan is primary.

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

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

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

4. Length of coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary. If none of the preceding requirements determines the primary plan, the allowable expenses will be shared equally between the plans.

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

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

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

Definitions

An "**Allowable Expense**"**,** with respect to a non-participating provider, is the Reasonable and Customary amount for any necessary medical, or health care service which is covered (at least in part) by one of the plans. If a health plan provides services (rather than cash payments) a dollar value will be assigned in order to use this provision.
When the primary plan penalizes an Insured Individual for not complying with plan provisions, such as failing to pre-certify, the amount of the reduction is not considered an Allowable Expense.

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

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

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

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for medical care, treatment, supplies, or services not listed in the types of Covered Expenses;
2. for medical care, treatment, supplies or services for the Insured Individual in his/her home country or country of regular domicile;
3. for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, abortion (except spontaneous and non-elective abortion), circumcision (except as covered under the Newborn Infants - Well Baby Care provision), learning disabilities, immunization, obesity, allergy tests, vitamins, and antitoxins;
4. for routine physical or health examinations, except if listed as a Covered Expense under the Medical Benefits section;

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

"Emergency Medical Condition" means the sudden, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, including severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that absence of immediate medical care to result in one of the following:

1. placing the patient’s health, or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

“Emergency Services” means inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Student Health Center" means an ambulatory care facility affiliated or contracted with the Policyholder that at a minimum maintains a staff consisting of a nurse director/nurse practitioner, staff nurses and a staff physician or an arrangement with a physician to perform office visits.

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

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

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

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

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

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

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

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

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

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

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

There are many doctors and hospitals available. Go to www.LewerMark.com and click "Find a Doctor." Select CIGNA as the PPO network.

CLAIMS PROCEDURE

Written notice of any event that may lead to a claim under the policy must be given to the Company or its authorized administrator within 60 days after the event, or as soon thereafter as reasonably possible. When the Company receives notice of the claim, We will send claim forms for filing.
Written proof of loss must be furnished to the Company within 90 days after the date of loss or as soon thereafter as reasonably possible. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss.

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

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

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

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

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

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

Right of Reimbursement: The Company shall have a lien against any recovery received by an Insured Individual as compensation for an Injury or Bodily Infirmity to the extent that the Insured Individual received benefits for such Injury or Bodily Infirmity under the coverage of the Policy. The Company's lien will apply to such recovery made by the Insured Individual from any person, or entity that was responsible for causing such Injury or Bodily Infirmity or their insurers.

The Insured Individual will not be required to return to the Company more than the amount which was recovered for such Injury or Bodily Infirmity.

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

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

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

NOTICE OF GRIEVANCE PROCEDURES FOR INDIANA RESIDENTS

If You have questions about any decisions related to Your coverage with Trustmark Life Insurance Company (Trustmark), You may call the third party administrator, The Lewer Agency at 1-800-821-7710 and a Customer Service Representative will assist You.

LEVEL 1: You, or Your personal representative may submit an oral or written request for a formal grievance review, if You have a complaint about any of the following:

- Trustmark's decisions, policies, or actions related to coverage of health care services.
- Claims payment or handling;
- The contractual relationship between a Covered Person and Trustmark.
- The outcome of an appeal on a denial of certification of an admission or continued stay.
- The availability of participating providers.
- The determination that a proposed service is not appropriate or medically necessary, or that a proposed service is experimental or investigational.

If You feel Our determination on any of the above did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may file a grievance.

- We will, within 5 business days after receiving Your grievance, provide oral or written acknowledgment of the request.
- A decision will be made within 20 business days after receiving all the information necessary to complete the review.
- You will be informed of the grievance resolution, and Your right to appeal the decision, within five (5) business days after the investigation is completed.
- If We are unable to make a decision within that time frame due to circumstances beyond Our control, We will notify You, in writing and before 20th business day, of the reason for delay. You will then receive a written decision regarding the grievance and Your right to appeal the decision within additional 10 business days.

Written requests should contain the issues and comments which are pertinent and should be sent or faxed to:

The Lewer Agency, Inc.
Attn: Grievance Appeals
4534 Wornall Road
Kansas City, MO 64111
Fax (816) 960-7064

Or You may call The Lewer Agency at 1-800-821-7710 (toll free) for information or to make a formal grievance request.

LEVEL 2-GRIEVANCE APPEAL: If You feel Our determination did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may request an appeal of the resolution of the initial grievance review.

- We will, within 5 business days after receiving Your Grievance Appeal request, provide oral or written acknowledgment of the appeal. At that time We will inform You of the date on which a panel will meet to discuss Your appeal and of Your right to appear in person, or, if You are unable to appear, how to otherwise communicate with the panel, for Grievance Appeals regarding medical necessity or experimental or investigational procedures.
- A decision will be made within 45 days after receiving Your Grievance Appeal request.
- You will be informed of the Grievance Appeal resolution within five (5) business days after the investigation is completed.
- If We deny Your claim for medical services at the Grievance Appeal level, We will advise You that Our decision is a Final Adverse Decision and advise You of Your right to request an External Review by an independent review organization, or to obtain additional information, at the address or phone number listed above.

LEVEL 3-EXTERNAL REVIEW: If You feel that Our determination of a Final Adverse Decision did not comply with the terms of Your policy/certificate, You, or Your personal representative on Your behalf, may file a written request for an External Grievance Review no more than forty-five (45) days after You are notified of he Grievance Appeal determination concerning the following:

- An adverse determination of appropriateness.
- An adverse determination of medical necessity.
- The contractual relationship between a Covered Person and Trustmark.
- A determination that a proposed service is experimental or investigational, made by Us or one of Our agents regarding a service proposed by Your treating health care provider.

We will provide an expedited External Grievance Review for a grievance related to an illness, disease, condition, injury or a disability if the time frame for a standard review would seriously jeopardize Your life, health or Your ability to reach and maintain maximum function. We will provide a Standard Grievance Review for all other grievances.

- A decision will be made within 3 business days after an Expedited External Grievance is filed and You will be notified within 24 hours after the determination is made.
- A decision will be made within 15 business days after a Standard External Grievance is filed and You will be notified within 72 hours after the determination is made.

You will not be required pay any costs associated with the services of an independent review organization. We are responsible for all associated costs.

You may only file one external grievance request per Grievance Appeal resolution. In addition, if You have the right to an external review by Medicare, You may not request an External Grievance Review under this process.

HIPAA

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

IMPORTANT NOTICE

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

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

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

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

Insured By:
Trustmark Life Insurance Company