4 Ever Life Insurance Company

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Certificate of Coverage

Global Citizens Association

Xplorer Premier

Group Short Term Medical Coverage
Non-Renewable
Certificate of Coverage Number: 4EL-5001-12
Effective Date: November 1, 2012

The Insurance Coverage Area is any place that is anywhere in the world.

The benefits provided by this Certificate are not subject to the guaranteed renewability and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Insured Person may not purchase insurance for a period longer than the current Period of Coverage.

SECRETARY

H F Bleicham, III
PRESIDENT

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Limited Benefit, Please Read Carefully

Form 54.1403

I. Introduction

About This Plan

This Certificate of Coverage is issued by 4 Ever Life Insurance Company ("Insurer") through a policy issued to the Global Citizen Association.

In this Plan, "Insurer" means the 4 Ever Life Insurance Company. The "Eligible Participant" is the person who meets the eligibility criteria of this Certificate. The term "Insured Person," means the Eligible Participant and any Insured Dependents.

The benefits of this Plan are provided only for those services that the Insurer determines are Medically Necessary and for which the Insured Person has benefits. The fact that a Physician prescribes or orders a service does not, by itself, mean that the service is Medically Necessary or that the service is a Covered Expense. If the Eligible Participant has any questions about whether services are covered, he/she should consult this Certificate of Coverage or telephone the Insurer at the number shown on his/her identification card.

This Certificate of Coverage contains many important terms (such as "Medically Necessary" and "Covered Expense") that are defined in Part III and capitalized throughout the Certificate of Coverage. The Eligible Participant may wish to consult Part III for the meanings of these words as they pertain to this Certificate of Coverage before reading through this Certificate of Coverage.

The Insurer has issued a Policy to the Group identified on the Eligible Participant's identification card. The benefits and services listed in this Certificate of Coverage will be provided for Insured Persons for a covered Illness, Injury, or condition, subject to all of the terms and conditions of the Policy.

Choice of Hospital and Physician: Nothing contained in this Plan restricts or interferes with the Eligible Participant's right to select the Hospital or Physician of the Eligible Participant's choice. Also, nothing in this Plan restricts the Eligible Participant's right to receive, at his/her expense, any treatment not covered in this Plan.

Providers outside the U.S.: Covered Expenses for these Foreign Country Providers are based on Reasonable Charges, which may be less than actual billed charges. Foreign Country Providers can bill the Eligible Participant for amounts exceeding Covered Expenses. HTH provides a list to Eligible Participants of Foreign Country Providers with whom HTH has contracted to accept assignment of claims and direct payments from the Insurer or its Administrator for Covered Expenses incurred by Insured Persons, thus alleviating the necessity of the Insured Person paying the Foreign Country Provider and submitting a claim for reimbursement. This particular group of Foreign Country Providers are not Participating Providers, but rather a group of Foreign Country Providers for whom HTH is able to provide background information and to arrange access for Insured Persons. If the Insured Person uses one of the Foreign Country Providers with whom HTH has contracted, any Copayment due this Foreign Country Provider is waived.

Services inside the U.S., Puerto Rico, and the U.S. Virgin Islands

Worldwide Insurance Services has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services inside the United States, Puerto Rico, or the United States Virgin Islands, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Worldwide Insurance Services and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care inside the United States, Puerto Rico, and the United States Virgin Islands, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). In some instances, you may obtain care from providers that do not contract with the Host Blue (non-participating healthcare providers). Worldwide Insurance Services payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Worldwide Insurance Services will remain responsible for fulfilling Worldwide Insurance Services contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services inside the United States, Puerto Rico, and the United States Virgin Islands, and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Worldwide Insurance Services.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Worldwide Insurance Services uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of U.S. States may require the Host Blue to add a surcharge to your calculation. If any of these state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers inside the U.S., Puerto Rico, and the U.S. Virgin Islands

1. Member Liability Calculation

When covered healthcare services are provided inside the United States, Puerto Rico, or the United States Virgin Islands by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Worldwide Insurance Services will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, Worldwide Insurance Services may use other payment bases, such as billed covered charges, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Worldwide Insurance Services will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment will make for the covered services as set forth in this paragraph.

Use of Administrator: The Insurer will use a third party administrator to perform certain of its duties on its behalf. The Group and the Insured Participant are hereby notified of the use of Worldwide Insurance Services, LLC as its administrator.

Benefit Overview Matrix

Following is a very brief description of the benefit schedule of the Plan. This should be used only as a quick reference tool. The entire Certificate of Coverage sets forth, in detail, the rights and obligations of both the Eligible Participant and the Insurer. It is, therefore, important that THE ENTIRE CERTIFICATE OF COVERAGE BE READ CAREFULLY!

The benefits outlined in the following table show the payment percentages for Covered Expenses AFTER the Eligible Participant has satisfied any Deductibles and prior to satisfaction of his/her Coinsurance Maximum. The Deductible and Co-Insurance amounts are selected by the Participant and reflected on their Confirmation of Coverage Page.

OVERVIEW MATRIX

	Limits Outside the U.S.	Limits In Network, U.S.	Limits Out-of-Network, U.S.
MEDICAL EXPENSES			
Lifetime Maximum Benefit	unlimited	unlimited	unlimited
Deductible* Any deductible paid for one column will be applied towards a deductible in another column	The amount shown in the Confirmation of Coverage Page as selected by the Insured Person per Calendar Year and limited to 2.5 times the individual Deductible per Family per Calendar Year	The amount shown in the Confirmation of Coverage Page as selected by the Insured Person per Calendar Year and limited to 2.5 times the individual Deductible per Family per Calendar Year	The amount shown in the Confirmation of Coverage Page as selected by the Insured Person per Calendar Year and limited to 2.5 times the individual Deductible per Family per Calendar Year
Payment Level One	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee.
Payment Level Two		Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the Coinsurance in another column		The amount shown in the Confirmation of Coverage Page as selected by the Insured Person per Calendar Year and limited to 2.5 time the individual Coinsurance per Family per Calendar Year	The amount shown in the Confirmation of Coverage Page as selected by the Insured Person per Calendar Year and limited to 2.5 time the individual Coinsurance per Family per Calendar Year
ACCIDENTAL DEATH AND DISMEMBERMENT	Deductible is not applicable. Maximum Benefit: Principal Sum up to $50,000		
REPATRIATION OF REMAINS	Deductible is not applicable. Maximum Benefit up to $25,000		
MEDICAL EVACUATION	Deductible is not applicable. Maximum Lifetime Benefit for all Evacuations up to $250,000		
BEDSIDE VISIT	Deductible is not applicable. Up to a maximum benefit of $2,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person		

* Deductible amounts incurred in the last three months of the Calendar Year (Oct, Nov, Dec) will apply towards the next year's Calendar Year deductible.

SCHEDULE OF BENEFITS
(Subject to Maximums, Coinsurance, and Deductibles in Overview Matrix)

Benefits	Outside the U.S.	In Network, U.S.	Out-of-Network, US
Preventive and Primary Care – Deductible is not applicable			
Preventive Care for Babies/Children: (Birth to Age 18) a. Office Visits/examination b. Immunizations, Lab work & X-rays done in conjunction with an office visit.	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Preventative Care For Adults: (Age 19 and Older) a. Office Visits/examination b. Routine Pap Smears, annual mammogram c. PSA For Men d. Annual Physical Examination/Health Screening e. Diagnostic Lab work & X-rays done in conjunction with an office visit.	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Primary Care Office Visits	After a $10 Copayment*, the Insurer will pay 100% of the Usual and Customary Fee.	After a $30 Copayment, the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Services and Supplies Provided by a Hospital – Copayments and Deductible apply if applicable			
Outpatient Hospital Care	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Ambulatory Surgical Center	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Inpatient Medical Emergency**	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.

Benefits	Outside the U.S.	In Network, U.S.	Out-of-Network, US
Inpatient Hospital Care	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Surgery, X-rays, In-hospital doctor visits, Organ/Tissue Transplant	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab work.	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Other Services – Insurer pays after the Deductible is satisfied, unless specifically noted			
Infusion Therapy (Administration of Drugs and other substances in ways other than oral; such as chemotherapy through a vein.)	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Ambulance Service	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Durable Medical Equipment	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Routine nursery care of a newborn child of a covered pregnancy	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Physical/Occupational/Speech Therapy/Medicine As many as 12 visits per Calendar Year	Deductible not Applicable The Insurer will pay 100% of the Usual and Customary Fee, up to $30 per visit	Deductible not Applicable The Insurer will pay 100% of the Negotiated Rate, up to $30 per visit	Deductible not Applicable The Insurer will pay 100% of the Usual and Customary Fee, up to $30 per visit

Benefits	Outside the U.S.	In Network, U.S.	Out-of-Network, US
Treatment of specified therapies, including Acupuncture and Chiropractic Care Up to $2,000 Maximum per Calendar Year Period of Coverage under the care of a licensed Physician	The Insurer will pay 100% of the Usual and Customary Fee	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee
Mental, Emotional or Functional Nervous Disorders – Inpatient Up to 60 days of inpatient confinement per Calendar Year	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Mental, Emotional or Functional Nervous Disorders – Outpatient Up to 40 visits per Calendar Year Additional visits for the remainder of that Calendar Year	75% 60%	75% 60%	75% 60%
Alcoholism or Substance Abuse – Inpatient in a Hospital, Non-hospital Residential Treatment Center or Day Care Center Up to 60 days of inpatient confinement per Calendar Year	The Insurer will pay 100% of the Usual and Customary Fee.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate.	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee.
Alcoholism or Substance Abuse – Outpatient Treatment Up to 40 visits per Calendar Year Additional visits for the remainder of that Calendar Year	75% 60%	75% 60%	75% 60%
Home Health Care Up to a maximum of 30 visits per Calendar Year	The Insurer will pay 100% of the Usual and Customary Fee	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee
Skilled Nursing Facilities As many as 50 days per Calendar Year	The Insurer will pay 100% of the Usual and Customary Fee, up to a maximum Covered Expense of $250 per day	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate, up to a maximum Covered Expense of $250 per day	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee, up to a maximum Covered Expense of $250 per day

Benefits	Outside the U.S.	In Network, U.S.	Out-of-Network, US
Hospice Up to a maximum Covered Expense of $5,000 per lifetime	The Insurer will pay 100% of the Usual and Customary Fee	Until the Coinsurance Maximum is satisfied, the Insurer will pay 80% of the Negotiated Rate. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate	Until the Coinsurance Maximum is satisfied, the Insurer will pay 60% of the Usual and Customary Fee. Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee
Dental Care required due to an Injury Up to $1,000 per Calendar Year maximum/$200 per tooth	100% of Covered Expenses	100% of Covered Expenses	100% of Covered Expenses
Pharmacy – Outside the U.S. Maximum 90 day supply	Deductible is not applicable. 100% of the actual charge up to a Calendar Year maximum of $500		

Pharmacy Benefits – Optional	Deductible is not applicable. The Co-payment stated below, up to a Calendar Year maximum of $25,000
Pharmacy – Outside the U.S. Maximum 90 day supply	Deductible is not applicable. 100% of the actual charge
Pharmacy – Inside the U.S. Maximum 90 day supply	Deductible is not applicable. The Copayment stated below:
1. Generic Drugs	All except a $10 Copayment per prescription, per 30 day supply
2. Brand name Drugs	All except a $25 Copayment per prescription, per 30 day supply
3. Injectables	All except a 30% Copayment per Prescription, per 30 day supply
Vision Care – Optional	Deductible not applicable. 70% of Covered Expenses per Calendar Year up to a maximum of $250 for Vision Care that is not the result of an Injury or Illness.
Dental Care – Optional	Deductible not applicable. Subject to a maximum Covered Expenses of $1,500 per Calendar Year.
Preventative Dental Services	100% of Actual Cost
Primary Dental Services	80% of Actual Cost
Major Dental Services	50% of Actual Cost Major Dental Services are not covered during the first 3 months the Insured Person is insured.
Orthodontic Dental Care	No Deductible. 50% of Actual Cost up to a Lifetime Maximum of $1,000 Orthodontic expenses are not covered during the first 3 months the Insured Person is insured.

* Copayment waived when visiting an HTH Worldwide contracted provider.

** Emergency room visits that do not result in inpatient admissions will be subject to a $50 penalty.

II. Who is eligible for coverage?

Eligible Participants and their Eligible Dependents are the only people qualified to be covered by the Policy. The following section describes who qualifies as an Eligible Participant or Eligible Dependent, as well as information on when, who to enroll, and when coverage begins and ends.

Who is Eligible to Enroll Under This Plan?

An Eligible Participant:
1. Is a member of the Global Citizens Association and is covered under the Policy.
2. Has submitted an enrollment form, if applicable, and the premium to the Insurer.

Eligible Participant – An Eligible Participant includes:

Eligible Member
An Eligible Member is a bona fide member in good standing of the Global Citizens Association. An Eligible Member resides outside his/her Home Country and is scheduled to reside outside his/her Home Country for a period greater than 3 months.

Eligible Dependents
An Eligible Dependent means a person who is the Eligible Participant's:
1. Spouse, partner;
2. own or spouse's/partner's unmarried natural child, stepchild or legally adopted child who has not yet reached age 26;
3. own or spouse's/partner's own unmarried child, of any age, enrolled prior to age 19, who is incapable of self support due to continuing mental retardation or physical disability and who is chiefly dependent on the Eligible Participant or spouse/partner. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's 19th birthday and annually thereafter.

As used above:
1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
3. The term "partner" means an Eligible Participant's domestic partner.
4. The term "domestic partner" means a person of the same or opposite sex who:
   a. is not married or legally separated;
   b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
   c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;
   d. occupies the same residence as the Eligible Participant;
   e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
   f. as entered into a "domestic partnership arrangement" with the named Insured.
5. The term "domestic partnership arrangement" means the Eligible Participant and another person of the same or opposite sex has any three of the following in common:
   a. joint lease, mortgage or deed;
   b. joint ownership of a vehicle;
   c. joint ownership of a checking account or credit account;
   d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
   e. designation of the domestic partner as a beneficiary of the member's will;
   f. designation of the domestic partner as holding power of attorney for health care; or
   g. shared household expenses.

A person **may not** be an Insured Dependent for more than one Insured Participant.

Additional Requirements for an Eligible Participant and Eligible Dependents: An Eligible Participant or an Eligible Dependent must meet the following requirements:
1. Citizen of the U.S. or permanent resident of the U.S. (as defined by the immigration code of the U.S.), or
2. employed by a company with offices in the U.S.; and
3. under Age 75.

Application and Effective Dates
Coverage for an Eligible Participant and his or her Eligible Dependents will become effective if the eligible person submits a properly completed application to the Insurer, is approved for coverage by the Insurer, and the Group and or the Eligible Participant pays the Insurer the premium. The Effective Date of Coverage under the Plan is indicated below:

1. Any person who qualifies as an Eligible Participant of the Group on the day prior to the Effective Date of the Policy, or any person who has continued group coverage with the Group under applicable federal or state law on the date immediately preceding the Effective Date of the Policy, is eligible as of the Effective Date of the Policy. The application, if applicable, for this Eligible Participant should be submitted with the Group application.
2. The Effective Date for a participant who becomes eligible after the Effective Date of the Policy will be the first of the month following the Waiting Period (the Initial Eligibility Date), provided the Insurer receives a fully completed application prior to the Initial Eligibility Date. The Effective Date will be the first or the fifteenth, as chosen by the Eligible Participant, of the month following the date the Insurer approves the application.
3. If a person meets the above definition of an Eligible Dependent on the date the Eligible Participant is qualified to apply for the Plan, then the Eligible Dependent qualifies to apply at the same time that the Eligible Participant applies, and should be included on the Eligible Participant's application.
4. For a person who becomes an Eligible Dependent after the date the Eligible Participant's coverage begins, the Eligible Dependent is qualified to apply for the Plan within 31 days following the date he/she meets the above definition of an Eligible Dependent. Coverage for the Eligible Dependent will become effective in accordance with the following provisions subject to approval by the Insurer:
    a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's ` child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
    b. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is a spouse or minor child, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, an Insured Participant must enroll the Eligible Dependent within that 31-day period.
    c. Adopted Children: An Insured Participant's adopted child is automatically covered for Illness or Injury for 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. To continue coverage beyond 31 days, an Insured Participant must enroll the adopted child within 31 days from either the date of placement or the final decree of adoption.
    d. Other Dependents: A written application must be received within 31 days of the date that a person first qualifies as an Eligible Dependent. Coverage will become effective on the first day of the month following date of approval.
5. If the application is not received within the time frames outlined above, the Eligible Participant/Dependent will become a Late Enrollee. The Late Enrollee may become covered for Participant and/or Dependent coverage only at the start of the next Period of Coverage and after the Insurer receives and approves the application.

All applications, if applicable, must be approved by the Insurer for coverage to go into effect.

In no event will an Eligible Dependent's coverage become effective prior to the Eligible Participant's Effective Date of Coverage.

Notification of Eligibility Change

1. Any person who does not satisfy the eligibility requirements is not covered by the Plan and has no right to any of the benefits provided under the Plan.
2. The Group and/or the Insured Participant must notify the Insurer within 31 days of any change that affects an individual's eligibility under the Plan, including the additional requirements for an Eligible Participant and Eligible Dependents.

How Coverage Ends

The benefits provided by this Certificate terminate at the end of the current Period of Coverage. At the beginning of the next Period of Coverage you may re-apply for coverage. Any re-application is subject to submission of a properly completed application to the Insurer, the Insurer's approval of that application, and payment of the applicable premium to the Insurer by the Eligible Participant. Premiums will be based upon the attained age of the Covered Person at the beginning of the Period of Coverage

Insured Participants

The Insured Participant's coverage ends without notice from the Insurer on the earlier of:

1. the last day of the month after the date the Insured Participant no longer meets the definition of an Eligible Participant;
2. the end of the last period for which premium payment has been made to the Insurer;
3. the date the Policy terminates;
4. the end of any Period of Coverage;
5. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision.

Insured Dependents

The Eligible Participant's insured Dependent's coverage will end on the earlier of:

1. the date the Insured Participant's Insured Dependent no longer meets the definition of an Eligible Dependent as defined in the Plan;
2. the end of the period for which premium payment has been made to the Insurer;
3. the date the Policy terminates;
4. the date the Insured Participant's coverage terminates;
5. the end of any Period of Coverage
6. the date of fraud or misrepresentation of material fact by the Insured Dependent, except as indicated in the Time Limit on Certain Defenses provision.

Group and Insurer

The coverage of all Insured Persons shall terminate if the Policy is terminated. If the Insurer terminates the Policy then the Insurer will notify the Group of cancellation. In addition, the Policy may be terminated by the Group on any premium due date. It is the Group's responsibility to notify all Insured Participants in either situation.

The Policy may be terminated by the Insurer:

1. for non-payment of premium;
2. on the date of fraud or intentional misrepresentation of a material fact by the Group, except as indicated in the Time Limit on Certain Defenses provision;
3. on any premium due date for any of the following reasons. The Insurer must give the Group written notice of at least 30 days in advance if termination is due to:
    a. failure to maintain the required minimum premium contribution;
    b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
    c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.
4. on any premium due date if the Insurer is also canceling all Group Health Benefit Plans in the state or in a geographic Service Area. The Insurer must give the Group written notice of cancellation:
    a. at least 180 days in advance; and
    b. again at least 30 days in advance.

Extension of Benefits

If an Insured Person is Totally Disabled on the date of termination of the Policy, coverage will be extended. Benefits will continue to be paid under the terms of the Policy for Eligible Expenses due to the disabling condition. Extension of Benefits will continue until the earlier of:

1. the date payment of the maximum benefit occurs;
2. the date the Insured Person ceases to be Totally Disabled; or
3. the end of 90 days following the date of termination.

This Extension of Benefits is not applicable if the Policy is replaced by another carrier providing substantially equivalent or greater benefits.

III. Definitions

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Certificate, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

Accidental Injury means an accidental bodily Injury sustained by an Insured Person, which is the direct cause of a loss independent of disease, bodily infirmity, or any other cause.

Acupuncture means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body.

Advanced Practice Nurse means a duly licensed Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

Adverse Determination or Adverse Health Care Treatment Decision means a health care treatment decision made by or on behalf of the Insurer under this Plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an Insured Person. Health Care Treatment Decision means a decision regarding diagnosis, care or treatment when medical services are provided by the Plan, or a benefits decision involving determinations regarding medically necessary health care, Pre-existing Condition determinations and determinations regarding Experimental/ Investigational services.

Age means the Insured Person's attained age.

Aggregate Annual Benefit Maximum means the maximum amount of benefits to which you are annually entitled under the program for all covered services combined.

Alcoholism means a disorder characterized by a pathological pattern of alcohol use that causes a serious impairment in social or occupational functioning, also termed alcohol abuse or, if tolerance or withdrawal is present, alcohol dependence.

Ambulance Transportation means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

Ambulatory Surgical Facility means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Anesthesia Services means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist that may be legally rendered by them respectively.

Authorized Administrator means a company appointed by the Insurer to administer or deliver benefits listed in this Certificate

Autism Spectrum Disorders means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefit Period means the valid dates as shown in the Schedule of Benefits.

A Calendar Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

Certificate means this booklet, the Schedule of Benefits, including your application for coverage under the THE INSURER benefit program described in this booklet.

Certificate of Credible Coverage means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

Certified Nurse Midwife means a nurse-midwife who (a) practices according to the standards of the appropriate local licensing authority; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

1. is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
2. is a graduate of a program of nurse-midwives accredited by the appropriate local licensing authority.

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs.

Chiropractor means a duly licensed chiropractor.

Claim means notification in a form acceptable to THE INSURER that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which THE INSURER may request in connection with services rendered to you.

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.").

Claim Payment means the benefit payment calculated by THE INSURER, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.").

Clinical Laboratory means a clinical laboratory that complies with the licensing and certification requirements under the applicable federal, state and local laws.

Coinsurance is the percentage of Covered Expenses the Insured Person is responsible for paying (after the applicable Deductible is satisfied and/or Copayment paid). Coinsurance does not include charges for services that are not Covered Services or charges in excess of Covered Expenses. These charges are the Insured Person's responsibility and are not included in the Coinsurance calculation.

Coinsurance Maximum is the amount of Coinsurance each Insured Person incurs for Covered Expenses in a Calendar Year. The Coinsurance does not include any amounts in excess of Covered Expenses, the Deductible and/or any Copayments, Prescription Drug Deductible and Copayments, any penalties, or any amounts in excess of other benefit limits of this Plan.

Complications of Pregnancy are conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompression, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. Complications of Pregnancy do not include elective abortion, elective cesarean section, false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

A Continuing Hospital Confinement means consecutive days of in-hospital service received as an inpatient, or successive confinements for the same diagnosis, when discharge from and readmission to the Hospital occurs within 24 hours.

Coordinated Home Care means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Copayment is the dollar amount of Covered Expenses the Insured Person is responsible for paying. Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expenses.

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance.
Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Country of Assignment means the country for which the Eligible Participant has a valid visa, if required, and in which he/she is working and/or residing.

Course of Treatment is a planned, structured, and organized sequence of treatment procedures based on an individualized evaluation to restore or improve health function, or to promote chemical free status. A Course of Treatment is complete when the patient has finished a series of treatments without a lapse in treatment or has been medically discharged. If the Insured Person begins a series of treatments, it will count as one course of treatment, reducing the available benefits, even if the patient fails to comply with the treatment program for a period of 30 days.

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Expenses are the expenses incurred for Covered Services. Covered Expenses for Covered Services received from Participating Providers will not exceed the Negotiated Rate. Covered Expenses for Covered Services received from Non-Participating and Foreign Country Providers will not exceed Reasonable Charges. In addition, Covered Expenses may be limited by other specific maximums described in this Plan in the Overview Matrix, the Schedule of Benefits, under section IV, How the Plan Works and section V, Benefits - What the Plan Pays. Covered Expenses are subject to applicable Deductibles, penalties and other benefit limits. An expense is incurred on the date the Insured Person receives the service or supply.

Covered Person means the Insured, and any Eligible Dependents.

Covered Services are Medically Necessary services or supplies that are listed in the benefit sections of this Plan, and for which the Insured Person is entitled to receive benefits.

Creditable Coverage means coverage you had under any of the following:
1. A group health plan;
2. Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;
3. Medicare (Part A or B of Title XVIII of the Social Security Act);
4. Medicaid (Title XIX of the Social Security Act);
5. CHAMPUS (Title 10 U. S. C. Chapter 55);
6. The Indian Health Service or a tribal organization;
7. A State health benefits risk pool;
8. The Federal Employees Health Benefits Program;
9. A public health plan maintained by a State, county or other political subdivision of a State;
10. Section 5(e) of the Peace Corps Act.

Custodial Care Service means those services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the health care facility involved.

Deductible means the amount of Covered Expenses the Insured Person must pay for Covered Services before benefits are available to him/her under this Plan. The Annual Deductible is the amount of Covered Expenses the Eligible Participant must pay for each Insured Person before any benefits are available regardless of provider type.

Dental Prosthesis means prosthetic services including dentures, crowns, caps, bridges, clasps, habit appliances, partials, inlays and implants services, as well as all necessary treatments including laboratory and materials.

Dentist means a duly licensed dentist.

Doctor of Acupuncture means a person licensed to practice the art of healing known as acupuncture.

Diagnostic Service means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Dialysis Facility means a facility (other than a Hospital) whose primary function is the treatment and/ or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

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

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from

birth to age three who are certified by the by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

The Effective Date of the Policy is the date that the Group's or Trust's Policy became active with the Insurer.

The Effective Date of Coverage is the date on which coverage under this Plan begins for the Eligible Participant and any other Insured Person.

Eligible Charge means (a) in the case of a Provider other than a Professional Provider which has a written agreement with a Plan and/or our Authorized Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with a Plan and/or our Authorized Administrator to provide care to you at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of a Plan and/or our Authorized Administrator:

1. the charge which the particular Hospital or facility usually charges its patients for Covered Services, or
2. the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by a Plan and/or our Authorized Administrator.

Eligible Dependent (See 'Eligibility Rules' in Section II of this Plan)

Eligible Participant (See 'Eligibility Rules' in Section II of this Plan)

Eligible Person means a member of the Group who meets the eligibility requirements for this health and/or dental and/or medical evacuation and repatriation coverage, as described in the Eligibility Section of this Certificate.

Emergency (See Emergency Medical Care)

Emergency Accident Care means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

Emergency Medical Care means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

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

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Mental Illness Admission means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

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

Facility means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Family Coverage means coverage for you and your eligible dependent(s) under this Certificate.

Foreign Country is any country that is not the Insured Person's Home Country.

Foreign Country Provider is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America. A Foreign Country Provider may also be a supplier of medical equipment, drugs, or medications. Out Authorized Administrator provides Insured Persons with access to a database of Foreign Country Providers with whom it has made arrangements for accepting assignment of benefits and direct payments of Covered Expenses on behalf of the Insured Person.

Group refers to the business entity to which the Insurer has issued the Policy.

Group Administrator means the administrator assigned by your Group to respond to your inquiries about this coverage. The Group Administrator is not the agent of THE INSURER.

Group health insurance coverage means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

Group health plan means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

1. "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
2. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
3. "Health benefit plan" does not include:
    a. Coverage only for accident, or disability income insurance, or any combination thereof;
    b. Coverage issued as a supplement to liability insurance;
    c. Liability insurance, including general liability insurance and automobile liability insurance;
    d. Workers' compensation or similar insurance;
    e. Automobile medical payment insurance;
    f. Credit-only insurance;
    g. Coverage for on-site medical clinics; and
    h. Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
4. "Health benefit plan" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
    a. Limited scope dental or vision benefits;
    b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
    c. Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
5. "Health benefit plan" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
    a. Coverage only for a specified disease or illness; or
    b. Hospital indemnity or other fixed indemnity insurance.
6. "Health benefit plan" shall not include the following if offered as a separate policy, certificate or contract of insurance:
    a. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
    b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
    c. Similar supplemental coverage provided to coverage under a group health plan.

Group Policy or Policy means the agreement between THE INSURER and the Group, any riders, this Certificate, the Schedule of Benefits, the Benefit Program Application and any member application form of the persons covered under the Policy.

Hearing Aids means any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.

Home Country means the Insured Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.

Home Health Agencies and Visiting Nurse Associations are home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Eligible Participant's home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospices are providers that are licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as a hospice provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospital means any establishment that is licensed in the country where it operates and where the medical practitioner permanently supervises the patient. The following establishments are not considered as hospitals: rest and nursing homes, spas, cure-centers, and health resorts.

An Illness is a sickness, disease, or condition of an Insured Person, which first manifests itself after the Insured Person's Effective Date.

Individual Coverage means coverage under this Certificate for yourself but not your spouse and/or dependents.

Infertility means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one year.

Infusion Therapy is the administration of Drugs (prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

Initial Eligibility Date is the Effective Date for a participant who becomes eligible after the Effective Date of the Policy.

Initial Enrollment Period is the 31 day period during which an Eligible Member or Eligible Dependent first qualifies to enroll for coverage, as described in the 'Who is Eligible for Coverage' section of this Plan.

Injury (See Accidental Injury)

Inpatient means that you are a registered bed patient and are treated as such in a health care facility.

Insurance Coverage Area is the primary geographical region in which coverage is provided to the Insured Person.

Insured Dependents are members of the Eligible Participant's family who are eligible and have been accepted by the Insurer under this Plan.

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Plan.

Insured Person means both the Insured Participant and all other Insured Dependents who are covered under this Plan.

The Insurer means 4 Ever Life Insurance Company that is a nationally licensed and regulated insurance company.

Investigative Procedures (See Experimental/Investigational).

Investigational or Investigational Services and Supplies means procedures, drugs, devices, services and/or supplies which:
1. are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness; and/or
2. are awaiting endorsement by the appropriate government agency for general use by the medical community at the time they are rendered to you; and
3. specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the appropriate government agency at the time used or administered to you.

A Late Enrollee means any Eligible Participant or Eligible Dependent who submits his/her written application after the expiration of the Initial Enrollment Period or the Special Enrollment Period.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maternity Service means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy that, through vaginal delivery, results in an infant, who weighs *5* pounds or more.

Maximum Allowance means the amount determined by a Plan that Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers in the United States of America will be based on the Schedule of Maximum Allowances. A Plan may amend these amounts from time to time.

Medical Care means the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including the transportation primarily for and essential to medical care referred to in Paragraph

Medically Necessary means health care services or products provided to Covered Person or the purpose of preventing, diagnosing or treating a Sickness, Injury or disease or the symptoms of a Sickness, injury or disease in a manner that is:
1. Consistent with generally accepted standards of medical practice;

2. Clinically appropriate in terms of type, frequency, extent, site and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of "best practices" in the medical profession; and
5. Not primarily for the convenience of the Covered Person or Physician or other health care practitioner.

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered including psychotic disorders (including schizophrenia), dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders (including bulimia and anorexia), and Substance Abuse or Alcoholism-related disorders.

Negotiated Rate is the rate of payment that the Insurer has negotiated with a Participating Provider for Covered Services.

Network means the group of participating providers providing services to a managed care plan.

A Newborn is a recently born infant within 31 days of birth.

Non-Participating Hospital (out of network) is a Hospital that has not entered into a Participating Hospital agreement with the Insurer at the time services are rendered.

A Non-Participating Physician (out of network) is a Physician who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-Participating Provider (out of network) is a provider who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-U.S. Resident means an expatriate who is a U.S. Citizen or third country national residing outside of the United States.

Nursing at Home means physician prescribed Skilled Nursing Service at your residence immediately after or instead of inpatient or outpatient care treatment.

Nursing at Home Care Program means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Occupational Therapist means a duly licensed occupational therapist.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:
1. History (gathering of information on an Illness or Injury).
2. Examination.
3. Medical Decision Making (the Physician's diagnosis and Plan of treatment).

This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

Optometrist means a duly licensed optometrist.

Other Plan is an insurance plan other than this plan that provides medical, repatriation of remains, and/or medical evacuation benefits for the Insured Person.

Outpatient means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Partial Hospitalization Treatment Program means a planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

A Participating Hospital (in network) is a Hospital that has a Participating Hospital agreement in effect with the Insurer at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Participating Physician (in network) is a Physician who has a Participating Physician agreement in effect with the Insurer at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for Covered Services.

A Participating Provider (in network) is a Participating Physician, hospital, or other health care provider that has a Participating Provider agreement in effect with the Insurer at the time services are rendered. Participating Providers agree to accept the Negotiated Rate as payment in full for Covered Expenses.

A Period of Coverage is a period for which the insured member is insured, but not more than 364 days from the date when coverage first began.

Pediatric Preventative Care means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a physician and rendered to a child.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Physical Therapist means a duly licensed physical therapist.

Physical Therapy means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits and including licensed pastoral counselors and marriage and family counselors, certified nurse practitioners, Certified Nurse Midwives, registered nurse first assistants, licensed clinical professional counselors, and dental hygienists.

Plan is the set of benefits described in the Certificate of Coverage booklet and in the amendments to this booklet (if any). This Plan is subject to the terms and conditions of the Policy the Insurer has issued to the Group. If changes are made to the Policy or Plan, an amendment or revised booklet will be issued to the Group for distribution to each Insured Participant affected by the change.

Podiatrist means a duly licensed podiatrist.

Policy is the Group Policy the Insurer has issued to the Group.

Preexisting Condition means any disease, illness, sickness, malady or condition which was diagnosed or treated by a legally qualified physician prior to the effective date of coverage with consultation, advice or treatment by a legally qualified physician occurring within 6 months prior to the Coverage Date for the insured.

A Primary Plan is a Group Health Benefit Plan, an individual health benefit plan, or a governmental health plan designed to be the first payor of claims for an Insured Person prior to the responsibility of this Plan.

Private Duty Nursing Service means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse that is not providing this service as an employee or agent of a Hospital or other health care facility. Private Duty Nursing Service does not include Custodial Care Service.

Provider or Professional Provider means any health care facility (for example, a Hospital) or person (for example, a Physician, Dentist, Podiatrist, Psychologist, or Chiropractor) or entity duly licensed to render Covered Services to you.

Psychologist means a Registered Clinical Psychologist.

A Reasonable Charge, as determined by the Insurer, is the amount it will consider a Covered Expense with respect to charges made by a Physician, facility or other supplier for Covered Services. In determining whether a charge is Reasonable, the Insurer will consider all of the following factors:

1. The actual charge.
2. Specialty training, work value factors, practice costs, regional geographic factors and inflation factors.
3. The amount charged for the same or comparable services or supplies in the same region or in other parts of the country.
4. Consideration of new procedures, services or supplies in comparison to commonly used procedures, services or supplies.
5. The Average Wholesale Price for Pharmaceuticals.

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

Registered Clinical Psychologist means a Clinical Psychologist who is registered with a department of professional regulation or, in a state or country where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state or country where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.
Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

1. has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or
2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

Renal Dialysis Treatment means one unit of service including the equipment, supplies and administrative service that are customarily considered as necessary to perform the dialysis process.

Schedule of Benefits means the document attached to the Certificate showing the coverage and benefit amounts provided under your Group Policy.

The Insurer's Service Area is any place that is within twenty-five (25) miles of a Participating Provider.

Skilled Nursing Facility means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensee by the appropriate governmental authority to provide such services. This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Speech Therapist means a duly licensed speech therapist.

Speech Therapy means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psycho-social speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Substance Abuse Rehabilitation Treatment means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, or Clinical Professional Counselor, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment,

Surgery means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by our Authorized Administrator.

Temporomandibular Joint Dysfunction & Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Totally Disabled means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Usual & Customary (or U&C) Fee means the fee as reasonably determined by a Plan and/or our Authorized Administrator, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor, or Optometrist ("Professional Provider") who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists, Psychologists, Clinical Social Workers, Chiropractors, or Optometrists ("Professional Providers") of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

However, if a Plan and/or our Authorized Administrator reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by a Plan and/or our Authorized Administrator.

U.S. means the United States of America.

IV. How the Plan Works

The Insured Person's Plan pays a portion of his/her Covered Expenses after he/she meets his/her Deductible each Calendar Year. This section describes the Deductible and Copayments and discusses steps he/she should take to ensure that he/she receives the highest level of benefits available to him/her under this Plan. See Definitions (Section III) for a definition of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred by the Insured Person while covered under this Plan. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Plan, which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending the Insurer properly completed claim forms itemizing the services or supplies received and the charges.

Benefits

This Benefits section shows the maximum Covered Expense for each type of provider.

No benefits are payable unless the Insured Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Plan.

Participating Hospitals, Participating Physicians and Other Participating Providers

Covered Expenses for Participating Providers are based on the Insurer's Negotiated Rate. Participating Providers have agreed NOT to charge the Eligible Participant and the Insurer more than the Insurer's Negotiated Rates. In addition, Participating Providers will file claims with the Insurer for the Eligible Participant.

Non-Participating Hospitals, Non-Participating Physicians, and Other Non-Participating Providers

The amount that will be treated as a Covered Expense for services provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, eligible billed charges as outlined in the Hospital's Service Item Master Manual, or a Reasonable Charge as determined by the Insurer.

Hospitals, Physicians, and Other Providers

The amount that will be treated as a Covered Expense for services provided by a Provider will not exceed the lesser of actual billed charges, eligible billed charges as outlined in the Hospital's Service Item Master Manual, or a Reasonable Charge as determined by the Insurer.

Exception: If Medicare is the primary payer, Covered Expense does not include any charge:

1. By a Hospital in excess of the approved amount as determined by Medicare; or
2. By a Physician or other provider, in excess of the lesser of the maximum Covered Expense stated above; or
   a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
   b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

The Insured Person will always be responsible for any expense incurred which is not covered under this Plan.

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit schedule only:

1. When the services are not available through Participating Providers; or
2. When the services are for a Medical Emergency with benefits provided as follows:

   #### Hospital

   Initial services for a Medical Emergency will be paid at in-network benefit levels. Thereafter, payment will be reduced to out of network levels if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

   #### Physician or other provider

   Covered Expense will be paid at in-network benefit levels for initial care for a Medical Emergency.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Eligible Participant must pay before benefits are available. The Annual Deductible applies to all Covered Expenses, except those Office Visits for which a Copayment is required. A complete description of each Deductible follows. Only Covered Expenses are applied to any Deductible. Any expenses the Insured Person incurs in addition to Covered Expenses are never applied to any Deductible.

Deductibles will be credited on the Insurer's files in the order in which the Insured Person's claims are processed, not necessarily in the order in which he/she receives the service or supply.

If the Insured Person submits a claim for services which have a maximum payment limit and his/her Annual Deductible is not satisfied, the Insurer will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

Annual Deductible

The Insured Person's Annual Deductible is stated in the Overview Matrix per Insured Person per Calendar Year. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for any Covered Services incurred for services received from either Participating or Non-Participating Providers each Calendar Year before any benefits are available. The Annual Deductible does not apply to those Office

Visits for which a Copayment is required. Annual maximum Deductibles (if any) for the Insured Eligible Participant and his/her Eligible Dependents is stated in the Overview Matrix.

Coinsurance Maximums

The Coinsurance Maximum is the amount of Copayment each Insured Person incurs for Covered Expenses in a Calendar Year. The Coinsurance Maximum **does not** include any amounts in excess of Covered Expenses, Prescription Drug Deductible or Copayments, Annual Deductible, amounts applied to any penalties, or any amounts in excess of other benefit limits of this Plan.

The **in network** (Participating Providers) Coinsurance Maximum per Insured Person per Calendar Year is as stated in the Overview Matrix.

The **out-of-network** (Non-Participating Providers) Coinsurance Maximum per Insured Person per Calendar Year is as stated in the Overview Matrix.

Once the **in network** (Participating Providers) Coinsurance Maximum is met, the Insurer will pay the percentage of Reasonable Charges for Non-Participating Providers for the remainder of the Calendar Year as stated in the Overview Matrix.

Once the **out of network** (Non-Participating Provider) Coinsurance Maximum is met, the Insurer will pay the percentage of Reasonable Charges for Non-Participating Providers for the remainder of the Calendar Year as stated in the Overview Matrix.

In addition, if an Insured Participant has any Insured Dependents, once the Insured Participant and the Insured Dependents reach a the combined total of Coinsurance expenses from a Participating Provider (**in network**) as stated in the Overview Matrix, the Insurer will pay the percentage of the Negotiated Rate for Participating Providers for the remainder of the Calendar Year as stated in the Overview Matrix.

Plan Payment

After the Insured Participant satisfies any required Deductible, payment of Covered Expenses is provided as defined below:

First Level Payment

Until an Insured Persons satisfies his/her in network or out of network Coinsurance Maximum in a Calendar Year, the Insurer pays:

1. The balance of the Covered Expense after the Insured Person pays the Copayment for Office Visits to Participating Providers as stated in the Overview Matrix. The number of visits per Calendar Year for which the Insurer will pay is limited as stated in the Overview Matrix.
2. The percentage of Covered Expenses as stated in the Overview Matrix for routine pap smears and annual mammograms obtained from either a Participating or Non-Participating Provider.
3. The percentage of Covered Expense for Office Visits to Non-Participating Providers as stated in the Overview Matrix.
4. The percentage of Covered Expense for all other Covered Services obtained from a Participating Provider as stated in the Overview Matrix. The Insured Person pays the balance of the Covered Expense. Participating Providers will not charge more than the Negotiated Rate.
5. The percentage of Covered Expense for all other Covered Services obtained from a Non-Participating Provider. The Insured Person pays the balance of the Covered Expense, plus any amount in excess of the Covered Expense.

Second Level Payment

Once an Insured Person satisfies his/her in network (Participating Provider) Coinsurance Maximum in a Calendar Year, the Insurer pays:

1. The percentage of the Negotiated Rate as stated in the Overview Matrix for all other Covered Expenses obtained from a Participating Provider.
2. The percentage of the Reasonable Charge as stated in the Overview Matrix for Covered Expenses for routine pap smears and annual mammograms obtained from a Non Participating Provider.
3. The percentage of the Reasonable Charges as stated in the Overview Matrix for all other Covered Expenses obtained from a Non-Participating Provider.

Note that there are special limits on Covered Expenses for the following services as described in Section V (See Schedule of Benefits):

Please note any additional limits on the maximum amount of Covered Expenses in the Schedule of Benefits and the discussions of each specific benefit.

Penalties

A Penalty is an amount of Covered Expenses that is:

1. not counted towards the Insured Person's Coinsurance Maximum.
2. not eligible for benefit payments.

There are penalties associated with the following services.

A. Non-Emergency Outpatient Hospital emergency room services: There will be a $50 penalty per visit, unless the visit results in an inpatient admission into that Hospital immediately following the emergency room visit.

V. Benefits: What the Plan Pays

Before this Participating Provider Plan pays for any benefits, the Insured Person must satisfy his/her Annual Deductible and any Other Deductibles that may apply. After the Eligible Participant satisfies the appropriate Deductibles, the Insurer will begin paying for Covered Services as described in this section.

The benefits described in this section will be paid for Covered Expenses incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all terms, conditions, exclusions, and limitations of this Plan. All services are paid at percentages indicated and subject to limits outlined in Section IV, How the Plan Works.

Following is a general description of the supplies and services for which the Insured Person's Participating Provider Plan will pay benefits, if such supplies and services are Medically Necessary:

Services and Supplies Provided by a Hospital

For any eligible condition other than for Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse, the Insurer will pay indicated benefits on Covered Expenses for:

1. Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
2. Outpatient services and supplies including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.

Payment of Inpatient Covered Expenses are subject to these conditions:

1. Services must be those, which are regularly provided and billed by the Hospital.
2. Services are provided only for the number of days required to treat the Insured Person's Illness or Injury

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Professional and Other Services

The Insurer will pay Covered Expenses for:

1. Services of a Physician.
2. Services of an anesthesiologist or an anesthetist.
3. Outpatient diagnostic radiology and laboratory services. If these services are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services, there is no additional Copayment for these service. A Deductible may apply. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.
4. Cervical cancer screening tests and the Office Visit associated with those tests when ordered by the Insured Person's Physician, nurse practitioner or certified nurse midwife (The laboratory and x-ray charges relating to cervical screenings are not subject to the deductible/co-insurance provisions, although the deductible and coinsurance provision do apply to the office visit.)
5. Mammogram examinations, limited to one baseline mammogram and an annual mammography examination upon the recommendation of the Insured Person's physician. (Mammograms are not subject to the deductible/coinsurance provisions.)
6. Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Insured Person's Physician or nurse practitioner.
7. Radiation therapy and hemodialysis treatment.
8. Surgical implants.
9. Artificial limbs or eyes.
10. The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery.
11. Self-Administered injectable drugs.
12. Syringes when dispensed with self-administered injectable drugs (except insulin).
13. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
14. Services for the detection and prevention of osteoporosis for qualified individuals.
15. Rental or purchase of medical equipment and/or supplies that are **all** of the following:
    a. ordered by a Physician;
    b. of no further use when medical need ends;
    c. usable only by the patient;
    d. not primarily for the Insured Person's comfort or hygiene;
    e. not for environmental control;
    f. not for exercise; and
    g. manufactured specifically for medical use.

    Note: Medical equipment and supplies must meet **all** of the above guidelines in order to be eligible for benefits under this Plan. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment.

    The Insurer determines whether the item meets these conditions.

    Rental charges that exceed the reasonable purchase price of the equipment are not covered. All durable medical equipment used in Infusion Therapy will be excluded under this Plan except where specifically stated under the benefit for Infusion Therapy.

16. Colorectal cancer screenings: Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.

Ambulance Services

The following ambulance services are covered under this Plan:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or air service for transportation to and from a Hospital or Skilled Nursing Facility.
2. Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.

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

Services for Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse

Benefits for eligible treatment of Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse are payable at the same rate as for Physical Illness, subject to the limitations stated in the Schedule of Benefits:

Alcohol abuse, drug abuse and mental illness shall be limited to those disorders identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.

In order to qualify for inpatient benefits, services for Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse must meet the following conditions of service:

1. Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, Alcoholism or Drug Abuse that can be improved by standard medical practice. Covered expenses are subject to all the provisions of the group policy that would apply to any other illness.
2. The Insured Person must be under the direct care and treatment of a Physician for the condition being treated. The physician must certify that such Insured Person is suffering from Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse.
3. Services must be those, which are regularly provided and billed by a Hospital.
4. Services are provided only for the number of days required to treat the Insured Person's condition.
5. Services must be received in a Hospital, Day Care Center or Non-hospital residential facility.

The term "Physician" as used in this section means a psychologist, advanced practice registered nurse or social worker, who upon certification that the individual is suffering from Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse, may include subsequent referral to other treatment providers.

Dental Care for an Accidental Injury

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if:

1. they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident; and
2. are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition.

Injury as a result of chewing or biting is not considered an accidental injury. No benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

Covered Services for accidental dental include, but are not limited to:

1. oral examinations;
2. x-rays;
3. tests and laboratory examinations;
4. restorations;
5. prosthetic services;
6. oral surgery;
7. mandibular/maxillary reconstruction;
8. anesthesia.

Benefits are payable as stated in the Schedule of Benefits.

Durable medical equipment

Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices,

lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, and nails, plates. Coverage for any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Complications of Pregnancy

Complications of Pregnancy are covered under this Plan as any other medical condition. Benefits for complications of pregnancy shall be provided for all covered Insured Persons.

Annual Physical Examination/Health Screening

An Annual Physical Examination or Health Screening is included in the coverage according to the limits stated in the Schedule of Benefits.

Home Health Care

Home Health services are limited as stated in the Schedule of Benefits for the following services. Services must be furnished by a Home Health Agency or a Visiting Nurses Association.

Benefits are provided when the Insured Participant or Insured Dependents are confined at home under the active supervision of a Physician. The Physician must:

1. be treating the Illness or Injury that necessitates home health care; and
2. he or she must renew any order for these services at least once every 30 days.

A visit is defined as four or fewer hours of services provided by one of the following providers:

1. Services of a registered nurse.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
3. If the Insured Person is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
4. Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
5. Services of a medical social worker.

All home health care services and supplies directly related to Infusion Therapy are included in the Infusion Therapy benefit and are not payable under this home health care benefit.

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

Hospice Services

Benefits for Hospice services are limited as stated in the Schedule of Benefits.

The Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is 12 months or less, as certified by the attending Physician and submitted to the Insurer in writing. The Physician must consent to the Insured Person's care by the Hospice and must be consulted in the development of the Insured Person's treatment plan. The Hospice must submit a written treatment plan to the Insurer every 30 days.

To be eligible for this benefit, the provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. The provider must also be approved as a hospice provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Human Organ Transplants

Your benefits for certain human organ transplants will be limited to the amount as shown in the Schedule of Benefits. Benefits will be provided only for kidney, heart valve, heart, lung, heart/lung, or liver transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage with the Insurer, each will have their benefits paid by their own policy.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided only for you and not the donor.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.
4. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

In addition to the above provisions, benefits for heart, lung, heart/lung or liver transplants will be provided as follows:

1. Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.

2. Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.
4. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
    a. Transportation by air ambulance for the donor or the recipient
    b. Travel time and related expenses required by a Provider
    c. Drugs that are Investigational
    d. The cost of acquisition of the organ and any costs incurred by the donor

Infusion Therapy

Infusion Therapy is the administration of Drugs (Prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by feeding tube.

Covered Expense for Infusion Therapy (including all professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy) will not exceed the Average Wholesale Price as determined by the Insurer or the Negotiated Rate:

Covered Services for Infusion Therapy are as follows:
1. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
2. All necessary supplies and durable medical equipment including, but not limited to, bandages, cotton swabs, intravenous starter kits, tubing, syringes, needles, pump, pole, and electronic monitor.
3. The Infusion Therapy Drugs or other substances.
4. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

Conditions, Limitations, Exclusions applicable to Infusion Therapy benefits are as follows:
1. If performed in the home, services must be billed and performed by a provider licensed by state and local laws. Example: A Medicare-certified Home Health agency or a provider certified by the Joint Commission on Accreditation of Home Care Organizations.
2. If performed in any other outpatient setting, services must be billed by a qualified provider as defined in this Plan and licensed by state and local laws. Example: Physician's office, outpatient Hospital or Ambulatory Surgical Center.
3. The services must be consistent with the Illness, Injury, degree of disability and medical needs of the Insured Person receiving treatment. Benefits are provided for Covered Services only for the Authorized number of days necessary to treat the Illness or Injury, subject to the per-day maximum.
4. Services and Drugs or other substances used must be consistent with the accepted medical practice and not investigative or experimental.
5. For treatment, which has been prescribed and Authorized for a period greater than 7 days, only up to a 7-day supply per delivery is to be dispensed.
6. In addition to any per-day maximum, limitations on Pre-Existing Conditions or other exclusion or limitations in this entire Plan, Infusion Therapy benefits will not be provided for:
    a. drugs and medications that do not require a prescription;
    b. any Drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational Drugs;
    c. any Drug or medication prescribed for experimental indications (for example, progesterone suppositories);
    d. drugs or other substances obtained outside the United States;
    e. non-FDA approved homeopathic medications or other herbal medications;
    f. FDA-approved Drugs or medications prescribed for non-FDA approved indications or that do not meet the medical community practice standards, except for non-investigational FDA approved Drugs used for off-label indications;
    g. growth hormone treatment;
    h. charges for Incidental Supplies used by a provider in the administration of a therapy, including but not limited to: cotton swabs, bandages, intravenous starter kits, tubing and syringes;
    i. compounding fees for mixing or diluting Drugs, medications or solutions; or
    j. charges exceeding the Average Wholesale Price.

Mastectomy and Related Procedures

Benefits are payable for hospital and professional services under this Plan for mastectomy for the treatment of breast cancer as described in the previous pages. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:
1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the policy definition of “Medically Necessary.”

Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Outpatient Prescription Drugs
For Outpatient prescription drugs the Insurer will pay as stated in the Schedule of Benefits. The Insured Person will pay as stated in the Schedule of Benefits.

Physical and/or Occupational Therapy/Medicine
Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable only for services rendered by a Physician up to a the maximum payment and visits per Calendar Year as stated in the Schedule of Benefits. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Preventive and Primary Care for Children (Up To Age 18)
Payment will be provided for Covered Expense for the following services for an Insured Person under the age of 19 Years.
1. Childhood immunizations and routine physical examination associated with the immunization, including Physician services.
2. Medically appropriate laboratory tests, procedures and radiology services in connection with the examination.
3. Routine hearing and vision tests and Physician services in connection with those tests. (Hearing tests will include screening tests for newborns, including auditory brainstem response, otoacustic emissions or other appropriate nationally recognized screening test.)

Preventive and Primary Care for Children shall specifically provide coverage for:
1. measurements, sensory screening, neuro-psychiatric evaluation and developmental screening, including unlimited visits for minor children up to age 12 Years and 3 visits per Year for minor children ages 12 Years up to 18 Years of age; and
2. hereditary and metabolic screening at birth, urinalysis, tuberculin tests, hemacrit, hemoglobin and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy, as recommended by a physician.

Prosthetic appliances
Benefits will be provided for prosthetic devices, special appliances and surgical implants when:
1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders. This benefit is subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders and replacement of cataract lenses when a prescription change is not required.)

Services and Supplies Provided by a Skilled Nursing Facility
Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

For any eligible condition that is Insurer Authorized, the Insurer will pay Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:
1. The Insured Person must be referred to the Skilled Nursing Facility by a Physician.
2. Services must be those, which are regularly provided and billed by a Skilled Nursing Facility.
3. The services must be consistent with the Insured Person's Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
4. The Insured Person must remain under the active medical supervision of a Physician treating the Illness or Injury for which he/she is confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:
1. Personal items, such as TV, radio, guest trays, etc.
2. Skilled Nursing Facility admissions in excess of 50 days per Calendar Year.

Treatment of Specified Therapies
The Insurer will pay up to the maximum stated in the Schedule of Benefits for Covered Expenses for treatment received by the Insured Person who is under the care of a licensed Physician for treatment of the specified therapies stated in the Schedule of Benefits.

Treatment for TMJ (Temporomandibular joint dysfunction)
Medical services for TMJ are paid on the same basis as any other medical condition. Dental services (i.e. dentures, bridges, crowns, caps or other dental prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e. braces and other orthodontic appliances) are not covered by this Plan for any diagnosis, including TMJ.

Accidental Death and Dismemberment Benefit

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

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

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

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

The Principal Sum is stated in the Overview Matrix.

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

Repatriation of Remains Benefit

If Insured Person dies, while living outside of his/her home country, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

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

This benefit is available only to Insured Persons who are living outside of their Home Country

The benefit for all necessary repatriation services is listed in the Overview Matrix.

Medical Evacuation Benefit

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

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

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

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

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

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

The combined benefit for all necessary evacuation services is listed in the Overview Matrix.

Bedside Visit Benefit

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than 7 days, is likely to be hospitalized for more than 7 days or is in critical condition, while living outside of his/her home country, the Insurer will pay up to the maximum benefit as listed in Table 1 of the Schedule of Benefits for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one person designated by the Insured Person. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

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

This benefit is available only to Insured Persons who are living outside of their Home Country while covered under this Plan.

The benefit for all Bedside Visits is listed in the Overview Matrix.

Dental Care – Optional: if chosen by the covered person

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Insurer until after receipt of a Dentist's or Physician's Claim form and/or the Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

The maximum amount available for you in dental benefits each Benefit Period is shown in the Schedule of Benefits. This is an individual maximum. This maximum applies to all of your Dental Covered Services, except for Orthodontic Dental Services where the maximum is the amount shown in the Schedule of Benefits.

Any expenses incurred beyond the benefit maximum are your responsibility.

Preventative Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for preventative treatment and necessary diagnostic examinations. Your Preventive Dental Services are as follows:

1. Oral Examinations – The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every Benefit Period;
2. Prophylaxis – The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each Benefit Period;
3. Topical Fluoride Application – Benefits for this application are only available to dependent children under age 19 and are limited to two applications each Benefit Period;
4. Dental X-rays – Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every twelve months;
5. Space Maintainers – Benefits for space maintainers are only available to dependent children under age 19 and not when part of orthodontic treatment;
6. Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Primary Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Primary Dental Services. Covered Expenses include:

1. Fillings
2. Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section
3. Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section
4. Endodontics
5. Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
6. Apicoectomies
7. Hemisection
8. Biopsies of Oral Tissue
9. Periodontics/Periodontal Therapy; Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
10. Periodontal examination – Benefits for periodontal examinations are limited to two per Benefit Period
11. Periodontal maintenance procedures – Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this

maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
12. Stainless Steel Crowns
13. Repair of Removable Dentures
14. Recementing of Crowns, Inlays, Onlays and Bridges
15. General Anesthesia/Intravenous Sedation – If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation
16. Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

Major Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Major Dental Services. Covered Expenses Include:
1. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
2. Fixed Bridgework
3. Bridge Repairs
4. Full and Partial Dentures
5. Denture Adjustments, Rebasing and Relining – During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until *5* years have elapsed. Also, benefits are not available for the replacement of a bridge or denture that could have been made serviceable.

Major Dental Services are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.

Orthodontic Dental Care

Orthodontic Dental Care applies only if the Group has chosen Dental Care and Orthodontic Dental Care as shown in the Schedule of Benefits.

The Insurer pays the percentage of Covered Expenses indicated in the Schedule of Benefits for necessary orthodontic treatment subject to a specific lifetime maximum also shown in the Schedule. Once this lifetime limit is reached, the Insured Person has no right to any further orthodontic treatment benefits.

Up to the age of 19, Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. The limitations are as follows:
1. Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any *5* year period, beginning with the date of the first visit to the Dentist;
2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
3. Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment

After your orthodontic treatment has been completed, no further orthodontic benefits will be provided until *5* years have elapsed.

Orthodontic expenses are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.

Special Limitations

No benefits will be provided under this Benefit Section for:
1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
   a. surgical services related to a congenital malformation;
   b. surgical removal of complete bony impacted teeth;
   c. excision of tumors or cyts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges are not covered.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

Vision Care – Optional: if chosen by the covered person

The Insurer will pay for Covered Expenses per Policy Year as stated in the Schedule of Benefits for routine Vision Care that is not the result of an Injury or Illness. The Deductible is not applicable.

Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and you must receive such care on or after your Coverage Date.

In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

1. Contact Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.
2. Frame means a standard eyeglass frame adequate to hold Lenses.
3. Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Covered Services

Benefits may be provided under this Benefit Section for the following:

1. Vision Examination
2. Single Vision Lenses
3. Bifocal Single Lenses
4. Bifocal Double Lenses
5. Trifocal Lenses
6. Lenticular Lenses
7. Contact Lenses
8. Frames

Special Limitations

Benefits will not be provided for the following:

1. Recreational sunglasses.
2. Medical or surgical treatment.
3. Drugs or any medication not administered for the purpose of a vision testing examination.
4. Orthoptics, vision training, subnormal vision aids, aniseikonic Lenses and tonoraphy.
5. Replacement of Lenses or Frames, which are lost or broken.

Benefit Payment for Vision Care

Benefits for Vision Care Covered Services will be provided for the services and at the payment levels listed in the Schedule of Benefits.

VI. Exclusions and Limitations: What the Plan does not pay for

The plan does not provide benefits for:

1. Hospitalization, services and supplies that are not Medically Necessary.
2. Services or supplies that are not specifically mentioned in this Certificate
3. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.
4. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government whether or not that payment or benefits are received.
5. Conditions caused by or contributed by: (a) An act of war; (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) An Insured Person participating in the military service of any country; (d) An Insured Person participating in an insurrection, rebellion, or riot; (e) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation; (f) An Insured Person voluntarily using illegal drugs; intentionally taking over the counter medication not in accordance with recommended dosage and warning instructions; and intentionally misusing prescription drugs.
6. Services or supplies that do not meet accepted standards of medical and/or dental practice.
7. Investigational Services and Supplies and all related services and supplies.
8. Custodial Care Service.
9. Routine physical examinations, unless otherwise specified in this Certificate.
10. Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of Mental Illness.
11. Cosmetic Surgery and related services and supplies, whether or not for psychological purposes, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases that occur after your Coverage Date.
12. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
13. Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
14. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
15. Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Certificate.
16. Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
17. Blood derivatives that are not classified as drugs in the official formularies.
18. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
19. Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).
20. Vision care services unless elected by your Group
21. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
22. Routine foot care, except for persons diagnosed with diabetes, including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet.
23. Immunizations, unless otherwise specified in this Certificate.
24. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.
25. Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.
26. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are members of the Group and each is covered separately under this Certificate.
27. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
28. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
29. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.
30. Investigational or experimental organ transplantation including animal to human organ transplants.
31. Consultations performed by you, your spouse, parents or children.
32. Charges for the services of a standby Physician.
33. Treatment for overweight conditions other than for morbid obesity.

34. Treatment for hair loss.
35. Growth Hormone treatment.
36. Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.
37. Dental Implants: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
38. Medical aids unless otherwise specified in this Certificate.
39. Services and treatment related to elective abortions.
40. Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate.
41. All contraceptive services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures unless stated otherwise.
42. All services related to the evaluation or treatment of fertility and/or Infertility, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization.
43. Cryopreservation of sperm or eggs.
44. Sex change operations.
45. Treatment of sexual dysfunction or inadequacy.
46. Non-prescription drugs.
47. Educational services except as specifically provided or arranged by the Insurer.
48. Nutritional counseling or food supplements, except for treatment of Phenylketonuria (PKU) and other inherited metabolic diseases and diabetes.
49. Charges by a provider for telephone consultations.

Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a Pre-existing Condition as defined in the Definitions section. This exclusion does not apply to a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption.

Exception: The Insurer will credit time an Insured Person was covered by Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of Coverage under this Plan, excluding the Waiting Period.

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

VII. Prescription Drug Benefits

Introduction and Definitions

To understand the Insured Person's Prescription Drug Benefits, it may be helpful to review these important terms:

Average Wholesale Price (AWP) is the average wholesale price of a Drug as determined by the Insurer.

Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented and is only produced by one manufacturer.

Drugs (Prescription Drugs) mean Prescription Drugs approved by state law or the Federal Food and Drug Administration for general use by the public. (See section on Conditions of Service for exceptions.) For purposes of this benefit, insulin is considered a Prescription Drug.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Maintenance Prescription Drugs are Prescription Drugs that are taken for an extended period of time to treat a medical condition.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. The Insured Person will be responsible for a larger portion of the Insured Person's pharmaceutical bill when the Insured Person goes to a Non-Participating Pharmacy.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. Call the Insured Person's local Pharmacy or call the toll-free Prescription Benefit Customer Service phone number (1-855-481-6647/1-610-254-5850 for a list of Participating Pharmacies in the Insured Person's area.)

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

1. Outpatient Drugs and medications that federal and/or State law, or national governing body if outside the United States, restrict to sale by Prescription only.
2. Insulin.
3. Insulin syringes prescribed and dispensed for use with insulin.
4. All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.

Conditions of Service

The Drug or medicine must be:

1. Prescribed in writing by a Physician and dispensed within one Calendar Year of being prescribed, subject to federal or state laws, or national governing body if outside the United States.
2. Approved for use by the Food and Drug Administration or national governing body if outside the United States.
3. For the direct care and treatment of the Insured Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included.
4. Purchased from a licensed retail Pharmacy.

The drug or medicine must not be used while the Insured Person is an inpatient in any facility.

The Prescription must not exceed a 90 day supply.

Reimbursement

Many Prescription Drugs are available in Generic form, which is more cost effective for the Insured Person. It may be to the Eligible Participant's advantage to ask the Insured Person's Physician to prescribe and the Insured Person's pharmacist to dispense Generic Drugs whenever possible.

The amount reimbursed by the Insurer for claims for Prescription Drugs is separate from and will not be applied toward any coinsurance amount described in the Covered Services section of this Plan.

When the Insured Person Goes to a Participating Pharmacy

When the Insured Person or an Insured Dependent has a Prescription filled, the Insured Person's identification card should be presented and the Insured Person should identify himself/herself as an Insured Person of the Insurer. The Pharmacy will calculate the Insured Person's remaining deductible and Copayment. the Insured Person will not need to submit claim forms but is responsible for paying Deductible and Co-insurance amounts to the Pharmacy. The Insured Person will have the following Copayment for each covered Prescription and/or refill:

1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.

2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits
3. For Injectibles, the Insured Person pays as stated in the Schedule of Benefits

For information on how to locate a Participating Pharmacy in the Insured Person's area, call 1-855-481-6647/1-610-254-5850.

When the Insured Person Goes to a Non-Participating Pharmacy in the U.S.

If the Insured Person purchases a Prescription Drug from a Non-Participating Pharmacy, he/she will be responsible for the amount stated in the Schedule of Benefits as well as any charge, which exceeds the Reasonable Charge of the Drug. He/she will need to have the pharmacist complete his or her portion of the Prescription Drug Claim Form. The Insured Person will pay the pharmacist for the Prescription, complete the Insured Person's portion of the Prescription Claim Form and then submit the Eligible Participant's claim to the Insurer for reimbursement within 15 months of the date of purchase. If the Insured Person has not satisfied his/her Deductible at the time his/her claim is submitted, the amount the Insured Person paid for the Prescription may be applied toward his/her Deductible amount. The Insured Person's Prescription is considered purchased on the date he/she receives the Drug for which the charge is made. The completed claim form should be submitted to the address included on the Prescription Claim Form.

When the Insured Person has his/her Prescription filled at a Pharmacy he/she will be reimbursed at the following rate for each covered Prescription and/or refill:

1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits plus any amount over Reasonable Charges.
2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits, plus any amount over Reasonable Charges.
3. For Injectibles, the Insured Person pays as stated in the Schedule of Benefits

Claims and Customer Service

Drug claim forms are available upon written request to Insurer.

If the Insured Person has any questions about his Prescription Drug Benefit, call the toll-free customer service number: 1-855-481-6647/1-610-254-5850.

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

1. Outpatient Drugs and medications that federal and/or State law restrict to sale by Prescription only.
2. Insulin.
3. Insulin syringes prescribed and dispensed for use with insulin.
4. All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.

Conditions of Service

The Drug or medicine must be:

1. Prescribed in writing by a Physician and dispensed within one Period of Insurance of being prescribed, subject to federal or state laws.
2. Approved for use by the Food and Drug Administration.
3. For the direct care and treatment of the Insured Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included.
4. Purchased from a licensed retail Pharmacy or other authorized entity in the country in which purchased.

The drug or medicine must **not** be used while the Insured Person is an inpatient in any facility.

The Prescription must not exceed a 90-day supply.

Prescription Drug Exclusions and Limitations

Prescription Drug reimbursement is subject to and treated as part of any benefit maximums, limitations on Pre-existing Conditions or any other exclusions or limitations contained in this entire Plan. In addition, reimbursement will not be provided for:

1. Drugs and medications not requiring a Prescription, except insulin.
2. Non-medical substances or items.
3. Drugs and medications used to induce non-spontaneous abortions.
4. Contraceptive Drugs and devices prescribed for birth control
5. Drugs and medications used for the purposes of sexual stimulation.
6. Dietary supplements, cosmetics, health or beauty aids.
7. Any vitamin, mineral, herb or botanical product, which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
8. Drugs taken while the Eligible Participant are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.

9. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
10. Syringes and/or needles, except those dispensed for use with insulin.
11. Durable medical equipment, devices, appliances and supplies.
12. Immunizing agents, biological sera, blood, blood products or blood plasma.
13. Oxygen.
14. Professional charges in connection with administering, injecting or dispensing of Drugs.
15. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
16. Drugs used for cosmetic purposes.
17. Drugs used for the primary purpose of treating infertility.
18. Drugs used for the purpose of treating hair loss.
19. Anorexiants or Drugs associated with weight loss.
20. Allergy desensitization products, allergy serum.
21. All Infusion Therapy is excluded under this Plan except as specifically stated in the Covered Services section.
22. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Preexisting Condition, or other contract limitation.
23. Growth Hormone Treatment.
24. Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
25. The replacement of lost or stolen Prescription Drugs.
26. Antihistamines.

Exception to Exclusions and Limitations for certain Cancer Drug treatment

An exception is made to the Exclusions and Limitations for certain cancer drug treatment. If a drug has not yet received formal FDA approval for use in treating a specific cancer, but is recognized for treatment of that specific cancer in one of the following references, it will be covered; AMA Drug Evaluations, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Drug Information, or recommended by review article or editorial comment in a major peer-reviewed professional journal. In addition, a service will not be considered experimental or investigational if it is part of a clinic trial program.

Third Party Liability

No benefits are payable for any Illness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Insurer will advance the benefits of this Plan to the Insured Person subject to the following:

1. The Insured Participant agrees to advise the Insurer, in writing, within 60 days of any Insured Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as the Insurer may require to facilitate enforcement of the claim. The Insured Participant and Insured Person also agree to take no action that may prejudice the Insurer's rights or interests under this Plan. Failure to provide notice of a claim or to cooperate with the Insurer, or actions that prejudice the Insurer's rights or interests, will be material breach of this Plan and will result in the Insured Participant being personally responsible for reimbursing the Insurer.
2. The Insurer will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Insured Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by the Insurer under this Plan for the treatment of the Illness, disease, Injury or condition for which the third party is liable.

Coordination of Benefits (COB) Provision:

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

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

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **The order of benefit determination rules** determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.
   When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable

expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. 1. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
   2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
   1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
   2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
      a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
         ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
      b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of This Plan. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive And Release Needed Information. Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The Insurer may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The Insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Insurer any facts it needs to apply those rules and determine benefits payable.

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

Right of Recovery. If the amount of the payments made by the Insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Benefits for Medicare Eligible Insured Persons

Insured Persons eligible for Medicare receive the full benefits of this Plan, except for those Insured Persons listed below:

1. Insured Persons who are receiving treatment for end-stage renal disease following the first 30 months such Insured Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
2. Insured Persons who are entitled to Medicare benefits as disabled persons, unless the Insured Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more employees (subject to COBRA legislation).
3. Insured Persons who are entitled to Medicare for any other reason, unless the Insured Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more employees (subject to COBRA legislation).

In cases where exceptions 1, 2 or 3 apply, the Insurer will determine the Insurer's payment and then subtract the amount of benefits available from Medicare. The Insurer will pay the amount that remains after subtracting Medicare's payment. Please note, the Insurer will not pay any benefit when Medicare's payment is equal to or more than the amount which we would have paid in the absence of Medicare.

For example: Assume exception 1, 2 or 3 applies to the Insured Person, and he/she is billed for $100 of Covered Expense. And assume in the absence of Medicare, the Insurer would have paid $80. If Medicare pays $50, the Insurer would subtract that amount from the $80 and pay $30. However, if in this example, Medicare's payment is $80 or more, the Insurer will not pay a benefit.

Alternate Cost Containment Provision

If it will result in less expensive treatment, the Insurer may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. It must be mutually agreed to by the Insurer, the Insured Person, and the Insured Person's Physician, Provider, or other healthcare practitioner. The Insurer's offering an alternate treatment plan in a particular case in no way commits the Insurer to do so in another case, nor does it prevent the Insurer from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Insured Person.

Terms of the Insured Participant's Plan

Entire Contract and Changes: The entire contract between the Group and the Insurer is as stated in the Policy and the entire contract between the Insured Participant and the Insurer is as stated in the Certificate of Coverage including the endorsements, application, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of the Insurer's officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.

Payment of Premiums: Premiums are payable in advance. Premiums must be paid monthly including any contributions the Insured Participant must make. The Insurer may change the premium rates from time to time. The Insurer must give the Group written notice of any premium rate change at least 30 days prior to the change. The Insurer may not increase premiums without first providing written notification to the Group at least 30 days prior to the date the increase is to take effect, with the exception of retroactive premium rate increases related to fraud or the intentional misrepresentation of a material fact.

Grace Period: There is a Grace Period of 31 days allowed for the payment of each premium after the first premium.

Representations: All statements made by the Insured Participant or the Group shall be considered representations and not warranties. The Insurer must provide the Insured Participant or the Group with a copy of any statements used to contest coverage.

Time Limit on Certain Defenses/Misstatements on the Application: After two Calendar Years from the Effective Date of the Policy, the Insurer will not contest the validity of the Policy. After two Calendar Years from the Insured Participant's Effective Date of Coverage, no misstatements on the Eligible Participant's application may be used to:

1. void this coverage, or
2. deny any claim for loss incurred or disability that starts after the 2 Calendar Year period.

The above does not apply to fraudulent misstatements.

Legal Actions: The Insured Person cannot file a lawsuit before 60 days after the Insurer has been given written proof of loss. No action can be brought after 3 Calendar Years from the time that proof is required to be given.

Conformity with State Statutes: If any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Policyholder resides, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

The Claims Process

Notice of Claim: Within 90 days after an Insured Person receives Covered Services, or as soon as reasonably possible, he/she or someone on his/her behalf, must notify the Insurer in writing of the claim.

Within 15 days after the Insurer receive the Insured Person's written notice of claim, the Insurer must:

a. acknowledge receipt of the claim;
b. begin any investigation of the claim;
c. specify the information the Eligible Participant must provide to file proof of loss. (The Insurer can request additional information during the investigation if necessary.)
d. send the Insured Person any forms the Insurer require for filing proof of loss. If the Insurer does not send the forms within this time period, the Insured Person can file proof of loss by giving the Insurer a letter describing the occurrence, the nature and the extent of the Insured Person's claim. The Insured Person must give the Insurer this letter within the time period for filing proof of loss.

Proof of Loss: Within 90 days after the Insured Person receives Covered Services, he/she must send the Insurer written proof of loss. If it is not reasonably possible to give the Insurer written proof in the time required, the Insurer will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to the Insurer no later than one Calendar Year from the date otherwise required.

All benefits payable under the Plan will be payable immediately upon receipt of written proof of such loss. Should the Insurer fail to pay the benefits payable under the Plan, the Insurer shall have 15 workings days thereafter within which to mail the Insured Person a letter or notice which states the reasons the Insurer may have for failing to pay the claim, either in whole or in part, and which also gives the Insured Person a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim has been received, the Insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the Insured Person the reasons the Insurer may have for denying such claim or any portion thereof.

Subject to proof of loss, all accrued benefits payable under the Plan for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the Insurer are liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Time Payment of Claims: Benefits for a loss covered under this Plan will be paid as soon as the Insurer receives proper written proof of such loss. Any benefits payable to the Eligible Participant and unpaid at the Eligible Participant's death will be paid to the Insured Person's estate.

Payment of Claims: The Insurer may pay all or a portion of any indemnities provided for health care services to the participating health care services provider, unless the Insured Participant directs otherwise in writing by the time proofs of loss are filed. The Insurer will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services provider directly to the Insured Person, unless the Insured Participant directs otherwise in writing by the time proofs of loss are filed. The Insurer cannot require that the services be rendered by a particular health care services provider.

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:
1. It is duly executed on a form acceptable to the Insurer; and
2. A copy is on file with the Insurer.

The Insurer assumes no responsibility for the validity or effect of an assignment.

Payment for services provided by a Participating Provider is automatically assigned to the provider. The Participating Provider is responsible for filing the claim and the Insurer will make payments to the provider for any benefits payable under this Plan. Payment for services provided by a Non-Participating Provider are payable to the Insured Participant unless assignment is made as above.

Payment to a Managing Conservator: Benefits paid on behalf of a covered dependent child may be paid to a person who is not the Insured Participant, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the child.

To be entitled to receive benefits, a managing conservator of a child must submit to the Insurer with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured Participant where the Insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

Misstatement of Age: If the age of an Insured Person has been misstated, an adjustment of premiums shall be made based on the Insured Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

Right to Recovery: If the Insurer makes benefit payments in excess of the benefits payable under the provisions of the Plan, the Insurer has the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.

Plan Administrator. In no event will the Insurer be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than the Insurer, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Eligible Participant's agent.

Waiver of Rights: Failure by the Insurer to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

Physical Exam and Autopsy: The Insurer has the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Insured Participant will not have to pay for it.

Required Information: The Group will furnish the Insurer all information necessary to calculate the Premium and all other information that the Insurer may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. The Insurer has the right to examine any records of the Group, any person, company or organization which may affect the Premiums and benefits of the Plan.

The Insurer's right to examine any records that exist:
1. During the time the Plan is in force; or
2. Until the Insurer pay the last claim.

The Insurer is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as independent contractors and not as employees, agents or representatives of the Insurer.

The Insurer will provide written notice to the Insured Participant within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if the Insurer determines that the Insured Participant or his/her Insured Dependents may be materially and adversely affected, and provide the Insured Participant with a current list of Participating Providers.

The Insurer will provide the Group with an updated list of local Participating Providers annually. If the Insured Participant needs a new provider listing for any other reason, he/she may call the Insurer at, and the Insurer will provide the Insured Participant with one.

The Insurer is entitled to receive from any provider of service information about the Insured Person which is necessary to administer claims on the Insured Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Insured Participant has authorized every provider furnishing care to disclose all facts pertaining to the Insured Participant's and his/her Insured Dependent's care, treatment, and physical condition, upon the Insurer's request. The Insured Participant agrees to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services. HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS.

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

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

There will be made available to the Insured Person, a member services representative to assist the Insured Person throughout the grievance process. The Insured Person also has a right to designate an outside independent representative to assist the Insured Person or the Insured Person's member services representative through the grievance process.

The insurer will respond to grievances it receives within 45 business days of receipt of the grievance. The insurer will inform the Insured Person in writing of the decision regarding the Insured Person's grievance.

All communications regarding the grievance/appeals process will be recorded, documented and maintained for at least 3 years.

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

There shall be three levels of appeal of a grievance decision.

Informal Internal Review: An Informal Internal Review shall consist of the Insured Person's right to discuss and appeal the insurer's grievance decision with the insurer's medical director or with the physician or health care provider designee who rendered the decision.

If an appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the Insured Person or his/her member service's representative. All other concurrent or prospective appeals conducted pursuant to this section shall be conducted by the insurer within 14 business days, unless the medical circumstances surrounding the case require the insurer to respond sooner.

If the Informal Internal Review is not concluded to the Insured Person's satisfaction, the insurer shall provide the Insured Person with a written explanation of the decision, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

If still dissatisfied, the Insured person or his/her member representative has a right to engage in a second level appeal.

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:
District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
825 North Capital Street, N.E. - 6th Floor
Washington, D.C. 20002
1(877) 685-1397 Fax: (202)478-1397

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases:
William P. White, Commissioner
Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor
Washington, D.C. 20002
(202) 727-8000 Fax: (202) 354-1085

Formal Internal Review: If dissatisfied with the Informal Internal Review decision, the Insured Person shall have a right to appeal before a reviewer or panel of physicians, or advanced practice registered nurses, or other health care professionals selected by the insurer.

The panel of reviewers selected by the insurer shall not have been involved in the initial grievance decision under review.

For all reviews which require medical expertise, the medical reviewer or in the case of a panel of reviewers, the panel shall consist of at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

A medical reviewer shall be a physician, or an advanced practice registered nurse or other appropriate health care provider possessing a non-restricted license to practice or provide care anywhere in the United States and have no history of disciplinary action or sanctions pending or taken against them by any governmental agency or professional regulatory body.

A medical reviewer shall be certified by a recognized specialty board in the areas appropriate to review.

All Formal Internal Reviews will be acknowledged by the insurer within 10 business days of receipt.

If the Formal Internal Appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the Insured Person or his/her member representative. All other concurrent or prospective appeals conducted pursuant to this section shall be conducted by the insurer within 30 business days, unless the medical circumstances surrounding the case require the insurer to respond sooner. The time may be extended at the request of the Insured Person or his/her member services representative.

If the Formal Internal Review is not concluded to the Insured Person's satisfaction, the insurer shall provide the Insured Person with a written explanation of the decision, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage

of appeal.

If the Insured Person or his/her member representative is dissatisfied with the Formal Internal Review decision, he/she may pursue an external grievance.

If the insurer fails to comply with any of the deadlines for completion of a formal internal appeal, the Insured Person or his/her member representative shall be relieved of his/her obligations under the Formal Internal Review Process and may proceed directly to the external appeal process.

External Grievance Process: If dissatisfied with the decision rendered in a Formal Internal Review, the Insured Person may pursue an External Review before an independent review organization.

Within 30 business days from receipt of a written decision of the formal internal appeal panel, the Insured Person shall file a written request with the director for an external review along with a signed release, allowing the insurer to release medical records pertinent to the appeal.

Upon receipt of the request for an external appeal, together with the executed release form, the Director shall determine whether:
1. The individual was or is a member of the health benefits plan;
2. The health care service which is the subject of the appeal reasonably appears to be a service covered by the health benefits plan;
3. The member or member representative has fully complied with the informal and formal internal appeals processes; and
4. The member or member representative has provided all information required by the independent review organization and the Director to make the preliminary determination, including the appeal form, and a copy of any information provided by the insurer regarding its decision to deny, reduce, or terminate a covered service, and the release form required pursuant to subsection (b) of this section.

Upon completion of the preliminary review, the Director shall notify the member or member representative and insurer in writing as to whether the appeal has been accepted for processing. If the appeal is accepted by the Director, the Director shall assign the appeal to an independent review organization for full review. If the appeal is not accepted by the Director, the Director shall provide a statement of the reasons for the non-acceptance to the member or member representative and the insurer.

The staff of the independent review organization that is assigned to the appeal shall have meaningful prior experience in performing utilization review, peer review, quality of care assessment or assurance, or the hearing of appeals. Any independent review organization, its staff, and its professional and medical reviewers, shall not have any material, professional, familial, or financial affiliation with the insurer that is a party to the appeal.

The Director may waive exhaustion of the informal and formal appeals process as a prerequisite for proceeding to the external appeals process in cases of emergency or urgent care.

The insurer shall provide timely access to all its records relating to the matter under review and to all provisions of the health benefits plan or health insurance coverage, including any evidence of coverage, "member handbook", certificate of insurance or contract and health benefits plan relating to the matter.

Upon acceptance of the appeal for processing, the independent review organization shall conduct a full review to determine whether, as a result of the insurer's decision, the member was deprived of any service covered by the health benefits plan.

The full review of an appeal of a health benefits decision shall be initially conducted by at least 2 physicians licensed to practice medicine in the District of Columbia, Maryland, or Virginia. On an exceptions basis, when necessary based on the medical, surgical, or mental condition under review, the independent review organization may select medical reviewers licensed anywhere in the United States who have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties, any applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.

The member or member representative and one insurer representative may request to appear in person before the independent review organization. The independent review organization shall conduct the hearing in the District of Columbia. The independent review organization's procedures for conducting a review, when the member or member representative or the insurer has requested to appear in person, shall include the following:
1. The independent review organization shall schedule and hold a hearing as soon as possible after receiving a request from a member or member representative or from an insurer representative to appear before the independent review organization. The independent review organization shall notify the member or member representative and insurer representative, either orally or in writing, of the hearing date and location. The independent review organization shall not unreasonably deny a request for postponement of the hearing made by the member or member representative or insurer representative.
2. A member or member representative and an insurer representative shall have the right to the following:
   a. To attend the independent review organization hearing;

b. To present his or her case to the independent review organization;
c. To submit supporting material both before and during the hearing;
d. To ask questions of any representative of the independent review organization; and
e. To be assisted or represented by a person of his or her choice.

When necessary, the independent review organization shall consult with a physician or advance practice registered nurse trained in the same specialty or area of practice as the type of treatment that is the subject of the grievance and appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

The independent review organization shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, the independent review organization shall complete its review within 30 business days, or 72 hours in the case of an expedited appeal, from the time the Director assigns the appeal to the independent review organization. An insurer shall provide all documentation to the independent review organization within 5 days of receipt of the notice of approval of the appeal by the Director, or within 24 hours of receipt of the notice of approval of the grievance, for an expedited review. If an insurer does not provide the independent review organization all documentation required by this subsection within the time frames, or obtain the necessary extensions, the independent review organization may decide the appeal without receiving the information. The independent review organization shall extend its review for a reasonable period of time as may be necessary due to circumstances beyond its or the insurer's control, but only when the delay will not result in increased medical risk to the member. In such an event, the independent review organization shall, prior to the conclusion of the initial review period, provide written notice to the member or member representative and to the insurer setting forth the status of its review and the specific reasons for the delay.

If the independent review organization determines that the member was deprived of medically necessary covered services, the independent review organization shall recommend to the Director the appropriate covered health care services the member should receive. The Director shall forward copies of the recommendation to the member or member representative and the insurer.

When necessary, the independent review organization shall refer a case for review to a consultant physician or other health care provider in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

The decision of the independent review organization shall be nonbinding on all parties and shall not affect any other legal causes of action.

This section shall not apply in cases directly involving Medicaid benefits.

Any appeal brought pursuant to this section by a member involving coverage provided pursuant to the Medicaid program shall be resolved in accordance with federal and District of Columbia laws, regulations, and procedures established for fair hearings and appeals for the Medicaid program.

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

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

4 Ever Life Insurance Company
c/o Worldwide Insurance Services,
One Radnor Corporate Center, Suite 100,
Radnor, Pennsylvania 19087
1-855-481-6647/1-610-254-5850

Dispute Resolution

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

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

Appeal Process

Expedited Claim Appeal

When an appeal concerns (a) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (b) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, you may request your appeal to be expedited.

Upon submission of an expedited appeal, you will be notified as soon as possible, but no later than 72 hours after the appeal is filed and the review agent receives all information necessary to complete the appeal.

First Level Appeal

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied, you may appeal your Claim. You may submit any additional information and comments on your Claim and you must request an appeal no later than 60 days after the denial by writing to:

Worldwide Insurance Services, LLC
One Radnor Corporate Center, Suite 100
Radnor, PA 19087
Telephone number: 1-855-481-6647/1-610-254-5850

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. If we require additional information, we will advise you within the first three days of your request.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Second Level Appeal

If your first level appeal is unsuccessful, and you want your appeal to be reviewed, you may request a second level appeal. You must request a second level appeal no later than 60 days after the first level appeal by writing to:

Worldwide Insurance Services, LLC
One Radnor Corporate Center, Suite 100
Radnor, PA 19087
Telephone number: 1-855-481-6647/1-610-254-5850

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. You may add information to the file by submitting it in writing.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.