SAMPLE

Global Citizen EXP NM

Major Medical Plan

Certificate of Coverage

The Insurance Coverage Area is any place that is anywhere outside of the United States.

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I. Introduction

About This Plan

This Certificate of Coverage is issued by The Insurer ("Insurer").

In this Plan, "Insurer" means the The Insurer. 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.

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 HTH Worldwide Insurance Services 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 amount is selected by the Participant and reflected on their Confirmation of Coverage Page.

OVERVIEW MATRIX

	Limits Outside the U.S.
MEDICAL EXPENSES	
Lifetime Maximum Benefit	$5,000,000
Deductible Any deductible paid for one column will be applied towards a deductible in another column	Deductible – Amount Shown in the Confirmation of Coverage Page as selected by the Participant per Insured Person per Policy Year and limited to 2.5 times the individual deductible per Family
Payment Level One	The Insurer will pay 100% of Covered Expenses.
ACCIDENTAL DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to $50,000
REPATRIATION OF REMAINS	Maximum Benefit up to $25,000
MEDICAL EVACUATION	Maximum Lifetime Benefit for all Evacuations up to $100,000
BEDSIDE VISIT	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

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

Benefits	Outside the U.S.
Preventative and Primary Care – Deductible is not applicable	
For Babies/Children: (Birth to Age 18) a. Office Visits/examination b. Immunizations, Lab work & X-rays	The Insurer will pay 100% of Covered Expenses.
For Adults: (Age 19 and Older) a. Routine Pap Smears, annual mammogram b. PSA For Men c. Annual Physical Examination/Health Screening	The Insurer will pay 100% of Covered Expenses.
a. Primary Care Office Visits	All except a $10 Copayment [1]
Professional Services – Insurer pays after the Deductible is satisfied	
a. Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab work.	The Insurer will pay 100% of Covered Expenses.
Inpatient Hospital Services – Insurer pays after the Deductible is satisfied	
a. Surgery, X-rays, In-hospital doctor visits, Organ/Tissue Transplant. [2]	The Insurer will pay 100% of Covered Expenses.
b. In-patient medical emergency	The Insurer will pay 100% of Covered Expenses.
Other Services – Insurer pays after the Deductible is satisfied, unless specifically noted	
Outpatient Medical Care [3]	The Insurer will pay 100% of Covered Expenses.
Maternity	Not Covered
Routine nursery care of a newborn child of a covered pregnancy	Not Covered
Ambulatory Surgical Center	The Insurer will pay 100% of Covered Expenses.
Physical/Occupational Therapy/Medicine	Deductible is not Applicable. Covered Expenses up to $30 per visit, and as many as 12 visits per Policy Year.
Treatment of specified therapies, including Acupuncture and Chiropractic Care	Covered Expenses up to $2,000 Maximum per Policy Year under the care of a licensed Physician
Ambulance Service	The Insurer will pay 100% of Covered Expenses.
Durable Medical Equipment	The Insurer will pay 100% of Covered Expenses.
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 Covered Expenses.
Home Health Care [2]	The Insurer will pay 100% of Covered Expenses up to a maximum of 30 visits per Policy Year
Skilled Nursing Facilities [2]	100% of Covered Expenses up to a maximum Covered Expense of $250 per day, as many as 50 days per Policy Year.
Hospice [3]	The Insurer will pay 100% of Covered Expenses up to a maximum of $5,000 per lifetime
Dental Care required due to an Injury	100% of Covered Expenses up to $1,000 per Calendar Year maximum/$200 per tooth

Benefits	Outside the U.S.
Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse	All benefits paid to the Insured participant of any Insured Dependent for Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse during each Insured Person's Lifetime is limited to a maximum equal to one third of the lifetime maximum for a physical illness, but not less than $80,000.
a. Mental, Emotional or Functional Nervous Disorders – Inpatient: Up to 20 days of inpatient confinement per Policy Year	The Insurer will pay 100% of Covered Expenses.
b. Mental, Emotional or Functional Nervous Disorders – Outpatient: First 30 visits per Policy Year	The Insurer will pay 80% of Covered Expenses.
c. Alcoholism or Drug Abuse – Inpatient in a Hospital, Non-hospital Residential Treatment Center or Day Care Center: Up to 30 days per Policy Year	The Insurer will pay 100% of Covered Expenses.
d. Alcoholism or Drug Abuse – Outpatient: Up to 30 visits per Policy Year	The Insurer will pay 80% of Covered Expenses.
Outpatient prescription drugs	50% of actual charge, up to an annual maximum of $500

1 Copayment waived when visiting an HTH Worldwide contracted provider.

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

3 In addition to pre-service review, certain services require Authorization to be eligible for maximum benefits. This applies to: Organ/Tissue Transplants, Home Health Services, Skilled Nursing Facilities, and Hospice. Failure to obtain authorization will result in a 50% reduction in benefits.

The following benefits are optional if chosen by the Participant and indicated on their Confirmation of Coverage document	
Outpatient prescription drugs – Optional Replaces the Outpatient Prescription Drugs Benefit as described in the Schedule of Benefits	80% of actual charges, up to an annual maximum of $3,000 per Insured Person.
Dental Care - Optional	Subject to a maximum Covered Expenses of $1,500 per Calendar Year
a. Preventative and Diagnostic	100% of Actual Cost
b. Restorative, Endodontic, Periodontics, Prosthodontics (Maintenance), and Oral Surgery	80% of Actual Cost
c. Major Restorative and Prosthodontics (Installation)	50% of Actual Cost
d. 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.

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 a Group 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 a membership Group or Association.

Eligible Dependents

An Eligible Dependent means a person who is the Eligible Participant's:

1. spouse;
2. unmarried natural child, stepchild or legally adopted child who has not yet reached age 19;
3. own or spouse's own unmarried child, of any age, enrolled prior to age 26, who is incapable of self support due to continuing mental retardation or physical disability and who is chiefly dependent on the Eligible Participant. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's 26th birthday and annually thereafter.
4. unmarried child, from their 19th to their 22nd birthday who is a full-time student attending an accredited college, university, vocational or technical school, and who is fully dependent upon the Eligible Participant for support. The Insurer may require proof of student status, but not more than once a Calendar Year;

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 all of the following requirements:

1. 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 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 if he or she submits an application within the 31 day Annual Open Enrollment Period that ends each Calendar Year on the anniversary of the Effective Date of the Policy. A Late Enrollee may **not** enroll at any time other than during the Annual Open Enrollment Period. A Late Enrollee's coverage must be approved by the Insurer in writing and will become effective on the first day of the month following the date 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

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 date the Lifetime Maximum Benefit of the Plan has been exhausted;
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 (unless due to exhaustion of the Lifetime Maximum Benefits);
5. the date the Insured Dependent's Lifetime Maximum Benefit is exhausted;
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 cancellation 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

The following definitions contain the meanings of key terms used in this Plan. Throughout this Plan, the terms defined appear with the first letter of each word in capital letters.

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.

Age means the Insured Person's attained age.

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.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It also must meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

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

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

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.

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 passport and, if required, a visa, 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.

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 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 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 provided under:
1. a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 101 et seq.);
2. a group health benefit plan provided by a health insurance carrier or health maintenance organization;
3. an individual health insurance policy or evidence of coverage;
4. Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
5. Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);
6. Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
7. A medical program of the Indian Health Service or of a tribal organization;
8. A state or political subdivision health benefits risk pool;
9. A health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.)
10. A public health plan as defined by federal regulations;
11. A health benefit plan under Section 5 (e), Peace Corps Act (22 U.S.C. Section 2504 (e)).

Custodial Care is care provided primarily to meet the Insured Person's personal needs. This includes help in walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of a medical professional.

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 Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

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.

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

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

Emergency (See Medical Emergency).

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.

A Full Time Student is a student enrolled at an accredited college, university, or trade school. The student must be currently attending classes, carrying at least 12 units per term.

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

Group Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:
1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provided by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota share, or similar basis.

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.

A 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.

A Hospital is a facility, which provides diagnosis, treatment, and care of persons who need acute inpatient hospital care under the supervision of Physicians. It must:

1. be licensed as a hospital and operated pursuant to law; and
2. be primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
4. be an institution which maintains and operates a minimum of five beds; and
5. have X-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. maintain permanent medical history records.

This definition excludes convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, those primarily affording custodial care or educational care.

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

Infertility is the inability to:

1. conceive after sexual relations without contraceptives for the period of one Calendar Year; or
2. maintain a pregnancy until fetal viability.

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 Employee 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).

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 The Insurer is a nationally licensed and regulated insurance company.

Investigative Procedures (See Experimental/Investigational).

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.

The Lifetime Maximum Benefit is the maximum amount of benefits available to each Insured Person during the person's lifetime. All benefits furnished are subject to this maximum amount.

A Medical Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:

1. Permanently placing the Insured Person's health in jeopardy, or
2. Causing other serious medical consequences; or
3. Causing serious impairment to bodily functions; or
4. Causing serious and permanent dysfunction of any bodily organ or part.

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

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

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

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

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

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.

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.

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.

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.

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.

A **Physician** means a physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state and/or country the Insured Person resides or is treated; and provides services covered by the Plan that are within the scope of his/her licensure.

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.

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

Pre-existing Condition means a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months immediately preceding the Eligibility Date.

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.

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).

A Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must:

1. be an institution licensed and operated pursuant to law; and
2. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; and
3. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
4. maintain a daily medical record on each patient.

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.

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.

Special Enrollment Period is the 31-day period during which an Eligible Participant or Eligible Dependent qualifies to enroll for coverage, as described in the "Who is Eligible for Coverage" section of this Plan.

Totally Disabled or Total Disability means:

1. As applied to Insured Participant, any period of time during the Insured Participant's lifetime in which he/she is unable to perform substantially all the duties required by his/her usual occupation, provided the disability commences within twelve (12) months from the date the disabling condition occurred;
2. As applied to a Dependent, not being able to perform the normal activities of a like person of the same age and sex.

The patient must be under the care of a Physician.

U.S. means the United States of America.

Utilization Review means those functions performed by the Insurer to evaluate whether the services provided, or to be provided, are Medically Necessary and are being provided in a medically appropriate setting.

The Waiting Period is a required period of continuous, full time group participation that must be completed before an Eligible Participant is eligible for the Insurer's coverage.

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 Policy 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.

Plan Payment

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

Limited Benefits

Regardless of the Insured Person's Coinsurance Maximum, the Insurer pays:

1. Up to: (i) the number of days per Policy Year as stated in the Overview Matrix for inpatient treatment; and (ii) the percentage of Covered Expenses and the number of treatments stated in the Overview Matrix in that Policy Year, for outpatient treatment of Mental, Emotional or Functional Nervous Disorders.
2. Up to the number of days per Policy Year stated in the Overview Matrix for inpatient treatment, up to the number of days per Policy Year stated in the Overview Matrix for detoxification, and the number of visits per Policy Year stated in the Overview Matrix for outpatient treatment of Alcoholism or Drug Abuse.
3. Up to the amount per visit stated in the Overview Matrix for services for Physical and/or Occupational Therapy/Medicine (limited to combined maximum of number of visits per Calendar Year stated in the Overview Matrix for first and second level payments combined)

For all other Covered Expenses

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.
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.

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

1. Home Health Services
2. Hospice Services
3. Skilled Nursing Facility Services

Lifetime Maximum Benefits

The combined total of all benefits paid to the Insured Participant or any Insured Dependent is limited to the maximum stated in the Overview Matrix during each Insured Person's lifetime, so long as the Insured Participant or the Insured Dependent remains insured under this Plan.

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.
B. Services received from Skilled Nursing facilities, Home Health services, Hospice services and Organ and Tissue transplants are subject to a 50% reduction in benefit penalty per Continuing Hospital Confinement or Course of Treatment if the Insured Person fails to obtain Authorization prior to receiving these services. (See Authorization Program in this section.)

Authorization Program

The Insured Person is required to obtain Authorization in order to receive full benefits for certain services. This Authorization program applies to the Home Health services, Hospice services, Skilled Nursing Facility services and Organ and Tissue transplants.

Benefits for the above mentioned services will be reduced by 50% if Authorization is not obtained prior to services being rendered.

Authorization will be provided only when:

1. The services are Medically Necessary;
2. The services are determined by the Insurer to be eligible under this Plan; and
3. The Physicians or other providers and/or the facility in which the surgery or procedure is to take place are approved by the Insurer for the services requested.

If the Insured Participant or an Insured Dependent requires Home Health services, Hospice services or Skilled Nursing Facility services, the Insured Person, or his/her Physician must call the Review Center at the toll-free telephone number shown on the Insured Participant's identification card before the services are rendered.

To initiate this authorization, the Insured Person's Physician must request Authorization at least 3 working days before a service requiring Authorization is performed by calling the Insurer Review Center at 1-(888)-243-2358. The Insured Person is responsible for making sure his/her Physician calls. If authorization is not approved for any reason, he/she and his/her Physician will be notified by telephone within one working day after the request for Authorization. He/she and his/her Physician will be sent a written notice within 3 working days of the telephone notice.

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:

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 services. 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.

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.

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.

Services and Supplies Provided by a Skilled Nursing Facility

To be eligible for maximum benefits, services of a Skilled Nursing Facility must be Authorized by the Insurer prior to services being rendered (See section titled Authorization Program in Section IV). 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 his/her 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.

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.

Dental Care for an Accidental Injury

Benefits are payable for dental care for an Accidental Injury to natural teeth that occurs while the Insured Person is covered under this Plan, subject to the following:

1. services must be received during the 6 months following the date of Injury;
2. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury;
3. damage to natural teeth due to chewing or biting is not considered an Accidental Injury under this Plan; and
4. Same as any injury 100% of Covered Expenses up to $1,000 per Calendar Year maximum/$200 per tooth.

In addition, the Plan provides benefits for up to 3 days of Inpatient Hospital services when a Hospital stay is ordered by a Physician and a Dentist for dental treatment required due to an unrelated medical condition. 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.

Dental Care – Optional Benefit. If chosen by the Insured and listed in their confirmation of coverage

The expenses described in the 3 classes below are reimbursed subject to a Policy Year maximum indicated in the Schedule of Benefits.

Preventative and Diagnostic Examinations Services.

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for preventative treatment and necessary diagnostic examinations. Covered Expenses include:

1. Regular oral examinations and regular x-rays;
2. Regular teeth cleaning;

3. Fluoride applications for children under age 19;
4. Sealant and space maintainers for children under age 16.

Deductibles do not apply to Preventative and Diagnostic Examinations Services.

Basic Restorative, Endodontic, Periodontics, Prosthodontics (Maintenance), and Oral Surgery Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for basic restoration endodontic, periodontal treatments and oral surgery. Covered Expenses include:

1. Oral surgery and related anesthesia;
2. Amalgam fillings;
3. Extractions;
4. Endodontic treatment (including root canal therapy);
5. Periodontal treatment (gum disease);
6. Repair of crowns, in-lays, on-lays, bridgework and dentures.

Major Restorative and Prosthodontics (Installation) Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for major restorative and prosthodontics (installation) services. Covered Expenses include:

1. Fixed bridgework;
2. Partial or full removable dentures;
3. Crowns;
4. Inlays, on-lays;
5. Gold fillings (only to the extent that the tooth cannot be restored with amalgam, silicate acrylic, or plastic restoration).

Major Restorative and Prosthodontics (Installation) Services are not covered during the first 3 months the Insured Person is covered.

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.

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

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.

Hospice Services

To be eligible for maximum benefits Hospice Services must be Authorized by the Insurer prior to services being rendered (See section titled Authorization Program in section IV). Benefits for Hospice services are limited to a lifetime maximum as stated in the Schedule of Benefits.

In addition, the Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is six 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.

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.

To understand the Infusion Therapy benefits available under the Insured Participant's Plan, it may be helpful to review these important terms:

Drugs: Medications or solutions approved by the Food and Drug Administration for general use by the public.

Average Wholesale Price (AWP): The Average Wholesale Price of a Drug as determined by the Insurer. AWP includes, but is not limited to, the preparation of the finished product.

Total Parenteral Nutrition (TPN): A solution given to the patient through a vein to supply nutrition. The solution typically contains dextrose (sugar), amino acids, electrolytes, vitamins, and lipids (fats).

Antimicrobial Therapy: Drugs or other substances typically administered through a vein or inhaler to treat infections caused by bacteria, viruses and fungi.

Cancer Chemotherapy: Drugs or other substances given to the patient to treat cancer.

Pain Management: Drugs given to the patient through a vein or other delivery system to decrease pain.

Intravenous Hydration: Fluids given to the patient through a vein to replace or supplement body fluids.

Aerosol Therapy: A Drug delivery system where medication is inhaled as a mist.

Other Therapies: Other therapies related to Infusion Therapies.

Tocolytic Therapy: Medication administered usually under the skin to arrest premature labor.

Course of Therapy: A course of therapy, as used in this section, refers to Physician prescribed Infusion Therapy, which has been Authorized by the Insurer prior to services being rendered for a specified number of days.

Incidental Supplies: Items used by a provider in the administration of Infusion Therapy, including but not limited to: cotton swabs, Bandages, intravenous starter kits, tubing, syringes, and needles for Drugs.

Compounding Fees: Charges for mixing or diluting Drugs, medications or solutions.

Infusion Therapy Benefit Schedule.

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 following:

Total Parenteral Nutrition (with or without lipids)	$250 per day
Antibiotics	AWP + $125/day
Chemotherapy	AWP + $150/day
Pain Management	$125 per day
Aerosol Therapy	AWP + $70/day
Tocolytic Therapy	$250 per day
Special Items	AWP
Intravenous Hydration	$75 per day

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 un-replaced 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.

Organ and Tissue Transplants

To be eligible for maximum benefits, organ and tissue transplants must be Authorized by the Insurer prior to services being rendered (see the Authorization Program section in Section IV). Benefits are payable for Hospital and professional services as described on the previous pages for:

1. An Insured Person who receives the organ or tissue.
2. An Insured Person who donates the organ or tissue.
3. An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person. Benefits are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Plan.

Outpatient Prescription Drugs

For Outpatient prescription drugs the Insurer 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.

Pregnancy and Maternity Care

This Plan does not provide maternity benefits for the Insured Participant or the Insured Participant's Insured Spouse or Dependent Children.

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.

Preventative 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 18 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.)

Preventative 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 one visit per Year for Covered Children 19 and 20 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.

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.

Accidental Death and Dismemberment Benefit

The Insurer will pay the benefit stated below if a 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, 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.

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 traveling 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 a 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 traveling 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 7 days or is in critical condition shall be made by the Administrator after consultation with the attending physician. No more than one (1) visit may be made during any 12 month period. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

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

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

Excluded Services

The Participating Provider Plan does not provide benefits for:

1. Any amounts in excess of maximum amounts of Covered Expenses stated in this Plan.
2. Services not specifically listed in this Plan as Covered Services.
3. Services or supplies that are not Medically Necessary as defined by the Insurer.
4. Services or supplies that the Insurer considers to be Experimental or Investigative.
5. Services received before the Effective Date of coverage or during an inpatient stay that began before that Effective Date of Coverage.
6. Services received after coverage ends unless an extension of benefits applies as specifically stated under Extension of Benefits in the 'Who is Eligible for Coverage' section of this Plan.
7. Services for which the Insured Person has no legal obligation to pay or for which no charge would be made if he/she did not have a health policy or insurance coverage.
8. Services for any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
9. 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, age 19 or older, being under the influence of illegal narcotics or non-prescribed controlled substances unless administered on the advice of a Physician.
10. Any services provided by a local, state or federal government agency except when payment under this Plan is expressly required by federal or state law.
11. Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption, or the Insured Person's employer.
12. Inpatient or outpatient services of a private duty nurse.
13. Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
14. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
15. Treatment of Mental, Emotional of Functional Nervous Disorders (including nicotine use) or psychological testing except as specifically stated in this Plan. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.
16. Treatment of Drug, alcohol, or other substance addiction or abuse, except as specifically stated in this Plan.
17. Dental services, dentures, bridges, crowns, caps or other dental prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically stated under Dental Care for an Accidental Injury in the Benefits section of this Plan.
18. Dental and orthodontic services for Temporomandibular Joint Dysfunction.
19. Orthodontic Services, braces and other orthodontic appliances.
20. 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.
21. Hearing aids.
22. Routine hearing tests except as provided under Preventative and Primary Care.
23. Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.
24. An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
25. Outpatient speech therapy.
26. Any Drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.
27. Any intentionally self-inflicted Injury or Illness. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
28. Cosmetic surgery or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or to Medically Necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.
29. Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.
30. Treatment of sexual dysfunction or inadequacy.
31. 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, except as specifically stated under Benefits, What the Plan Pays For Sterilization.

32. All contraceptive services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures unless stated otherwise.
33. Cryopreservation of sperm or eggs.
34. Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
35. Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method of treatment.
36. Routine physical exams (after one per year) or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority except as specifically stated under the Professional and other Services and Preventative and Primary Care sections of this Plan.
37. Charges by a provider for telephone consultations.
38. Items which are furnished primarily for the Eligible Participant's personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc.).
39. Educational services except as specifically provided or arranged by the Insurer.
40. Nutritional counseling or food supplements.
41. Durable medical equipment not specifically listed as Covered Services in the Covered Services or Infusion Therapy sections of this Plan. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings.
42. Any services received on or within 6 months after the Effective Date of coverage if they are related to a Pre-existing Condition as defined in the Definitions section.
43. Physical and/or Occupational Therapy/Medicine, except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.
44. All Infusion Therapy together with any associated supplies, Drugs or professional services are excluded except as specifically provided under the benefit for Infusion Therapy described in this Plan.
45. Growth Hormone Treatment.
46. Routine foot care 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.
47. Charges for which the Insurer is unable to determine the Insurer's liability because the Eligible Participant or an Insured Person failed, within 60 days, or as soon as reasonably possible to (a) authorize the Insurer to receive all the medical records and information the Insurer requested or, (b) provide the Insurer with information the Insurer requested regarding the circumstances of the claim or other insurance coverage.
48. Charges for the services of a standby Physician.
49. Charges for animal to human organ transplants.

Pre-existing Conditions

Benefits are not available for any services received: (1) on or within 6 months after the Eligibility Date of an Insured Person who is not a Late Enrollee; or (2) on or within 6 months after the Effective Date of Coverage for a Late Enrollee, 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 or 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.

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

If the Insured Person is covered by more than one group medical plan, the Insured Person's benefits under this Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each Insured Person, per Calendar Year, and are largely determined by District of Columbia law. Any coverage you have for medical benefits will be coordinated as shown below.

Definitions

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When the Insured Person sees these capitalized words, then he/she should refer to this Definitions provision.

Allowable Expense is any necessary, reasonable and customary item of expense, which is at least partially covered by at least one or more plans covering the Insured Person for whom claim is made.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage, except blanket student accident coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans, or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement, which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Primary Plan is that plan which will have its benefits determined first.

Secondary Plan is the plan, which will have its benefits determined after the Primary Plan.

This Plan is that portion of this Plan, which provides benefits subject to this provision.

Order of Benefits Determination

The following rules determine the order in which benefits are payable:

1. A plan, which has no Coordination of Benefits provision, pays before a plan, which has a Coordination of Benefits provision.
2. A plan which covers the Eligible Participant as an Insured Employee pays before a plan that covers the Eligible Participant as an Insured Dependent.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to Rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:
   A. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as an Insured Dependent pays first.
   B. If the parent with custody of the child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
      1. The plan which covers the child as an Insured Dependent of the parent with custody.
      2. The plan which covers the child as an Insured Dependent of the stepparent (married to the parent with custody).
      3. The plan which covered the child as an Insured Dependent of the parent without custody.
      4. The plan which covers the child as an Insured Dependent of the stepparent (married to the parent without custody).
   C. Regardless of (A) and (B) above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as an Insured Dependent of that parent pays first.
4. The plan covering the Insured Participant as a laid-off or retired employee or as an Insured Dependent of a laid-off or retired participant pays after a plan covering the Insured Participant as other than a laid-off or retired participant or the Insured Dependent of such a person. But if either plan does not have a provision regarding laid-off or retired participant, Rule 6 applies.

5. If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:
   a. First the benefits of a plan covering the Insured Person as an Employee, member or subscriber or dependent.
   b. Second the benefits under the continuation coverage.
6. When the above rules do not establish the order of payment, the plan on which the Insured Person has been enrolled the longest pays first unless two of the plans have the same effective date.

The Insurer's Rights Under This Provision

Right to Receive and Release Needed Information: Certain facts are needed to apply these COB rules. The Insurer may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or Group Health Benefit Plan administrator with whom the Insurer coordinates benefits.

Responsibility for Timely Notice: The Insurer is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value: If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and the Insurer's liability reduced accordingly.

Facility of Payment: If payments which should have been made under this Plan have been made under any Other Plan, the Insurer has the right to pay that Other Plan any amount the Insurer determines to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy the Insurer's liability under this provision.

Right of Recovery: If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, the Insurer has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

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

1. 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.

2. 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.

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

4. 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.

5. 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:
   a. void this coverage, or
   b. deny any claim for loss incurred or disability that starts after the 2 Calendar Year period.

   The above does not apply to fraudulent misstatements.

6. 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.

7. 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.

8. 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.

9. The Claims Process

   Notice of Claim: Within 20 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 due 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 have 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 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 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.

10. 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.

11. 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.

12. Plan Administrator – COBRA and ERISA. 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.

13. 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.

14. 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.

15. 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 are providers act as independent contractors and not as employees, agents or representatives of the Insurer.

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.

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

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

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

The Insurer

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 propose to resolve the grievance.

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