CitizenSecure℠

Including the US and Canada
(FORM CW29)

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ARTICLE 1 – INSURING

Certain Underwriters at Lloyds, London ("Underwriters") promise to provide the benefits described in the Master Policy. Underwriters make this promise in consideration of the Member's Application and payment of Premium.

HCC Medical Insurance Services is hereby recognized by Underwriters as the Plan Administrator. All communications, notices and payments required under this Certificate shall be transmitted through the Plan Administrator. Receipt by the Plan Administrator shall be considered receipt by Underwriters.

Underwriter's agreement is subject to all terms, conditions, provisions and exclusions of the Master Policy, including any Exhibits, Schedules, Endorsements and/or Riders attached thereto.

ARTICLE 2 – GENERAL PROVISIONS

A. ENTIRE AGREEMENT

The Master Policy, including any Exhibits, Schedules, Endorsements and/or Riders attached thereto, constitutes the entire agreement between Underwriters and the Assured. This Certificate issued to the Member, including the Member's Application and any Exhibits, Schedules, Endorsements and/or Riders attached hereto, is an outline of the insurance provided by the Master Policy. The Certificate does not extend or change the insurance provided by the Master Policy. The insurance described in this Certificate is subject to all terms, conditions, provisions and exclusions of the Master Policy, including any Exhibits, Schedules, Endorsements and/or Riders attached thereto.

B. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the Member shall not impose upon Underwriters any liability other than that specifically included in this insurance.

C. CURRENCY

The monetary limits and Premiums stated in this Certificate are in US dollars.

D. NOTICE

Any notice to any Member shall be placed in the United States Mail, postage prepaid, and addressed to the Member's mailing address on file with Underwriters on the date the notice is mailed. Members are required to promptly notify Underwriters of any change in mailing address.

ARTICLE 3 – CONDITIONS PRECEDENT

The following are conditions precedent to Underwriter's liability under this insurance:

A. PREMIUM

1. Rates: Rates shall be as set forth on the Declaration attached hereto.
2. Payment: Payment of the required Premium shall be remitted to Underwriters on or before the Due Dates(s) specified on the Declaration attached to the Certificate issued to the Member.
3. A grace period of 15 days will be allowed to Members for the payment

of each Premium except the first.

4. If any Premium is unpaid at the end of a grace period, all insurance shall terminate with respect to the Member, and Underwriter's liability shall cease with effect from the date through which premiums have been earned in accordance with the Short Rate Cancellation Table For Term of One Year, set forth in form SLC3(USA) attached to the Certificate issued to the Member. Premium is considered to be paid on the date the payment instrument is received by Underwriters, provided such instrument provides immediately available funds.

B. MISREPRESENTATION AND FRAUD

1. Application:
   Underwriters rely on the statements made by the Member on the Application and in connection with the making of the Application in determining whether or not the individual(s) included on the Application meets the Eligibility requirements and the underwriting requirements insurance hereunder. Any misstatement, concealment or fraud in the Member's Application, or in relation to any statement or warranty made by the Member or their authorized representative, whether in writing or otherwise, to Underwriters or their representatives, on or in connection with the Application shall render this insurance null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters.
2. Claims:
   Underwriters rely on the statements made by the Member on the Claimant's Statement and in connection with the submission of any claim hereunder in determining whether or not and to what extent benefits under this insurance may be payable. Any misstatement, concealment or fraud in the making of any claim hereunder shall render this insurance null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters. If any claim under this insurance shall be in any respect fraudulent or if any fraudulent means or devices are used by the Member or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters.

C. PROOF OF CLAIM

When Underwriters receive notice of claim, they will provide the Member with forms for filing Proof of Claim. The following is considered to be Proof of Claim:

1. A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments; and
2. Original itemized bills from Physicians, Hospitals and other providers; and
3. Original receipts for any expenses which have already been paid by or on behalf of the Member.

The Member shall have 60 days beginning on the last day of the Certificate Period to submit Proof of Claim to Underwriters. Subsequent to receipt of Proof of Claim, Underwriters may, at their sole discretion, request and require additional information,

including but not limited to medical records, necessary to confirm the validity of any claim prior to payment thereof.

D. APPEALING A CLAIM

1. TIME LIMIT

   In the event Underwriters deny all or part of a claim under this insurance, the Member shall have 90 days from the date the notice of denial was mailed to the Member's last known address to file a written appeal with Underwriters. The written appeal must include sufficient information to identify the claim under appeal and must specify the reason(s) for the appeal with supporting documentation, if applicable.

2. APPEAL PROCEDURE

   Within 30 days of Underwriters receipt of the appeal, Underwriters will review the claim. A written response will be forwarded to the Member. Within 60 days of receipt of Underwriters response to the appeal, the Member may initiate a second appeal. Within 30 days of Underwriters receipt of the second appeal, medical and/or claims personnel who were not involved in the original claim determination or the initial appeal will review the claim. A final determination will be made and a letter will be sent to the Member.

E. ARBITRATION

If any dispute shall arise as to the amount to be paid under this insurance (liability being otherwise admitted), such dispute shall be referred to arbitration in accordance with procedures of the American Arbitration Association. Where any dispute is by this provision referred to arbitration, the making of an award shall be a condition precedent to any right of action against Underwriters.

F. LEGAL ACTIONS

No action of law or equity may be brought to recover benefits under this insurance until 60 days after written Proof of Claim, as herein defined, has been provided to Underwriters. No such action may be brought after the end of three (3) years after the time written Proof of Claim, as herein defined, is required to be furnished.

G. WAIVER OF RIGHTS

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

H. CLAIMS COOPERATION

The Member and his/her Physician(s), Hospital(s) and other providers shall cooperate fully with Underwriters including granting full right of access to all related medical documentation, reports and evidence. Underwriters may deny coverage for any claim where there has been a refusal or material failure to so cooperate.

I. PATIENT ADVOCACY

Underwriters may determine that a particular claim or diagnosis occurring under this insurance may be placed under the Patient Advocacy program to ensure that Medically

Necessary services and supplies are provided in the most cost effective manner. In the event Underwriters determine that a claim or diagnosis meets the Patient Advocacy program requirements, Underwriters will notify the Member, and a Patient Advocate will be assigned to the Member. Thereafter, the Patient Advocate may make recommendations of alternative treatment settings and/or procedures and/or supplies, which may be more cost effective for the Underwriters and/or the Member. Such recommendations will be made with input from the Member and the Member's Physician(s) and will be made only when it can be reasonably demonstrated that the Medically Necessary services and supplies can be provided in a more cost-effective manner to Underwriters and/or the Member. Underwriters will use best efforts to evaluate and recommend alternative treatment settings and/or procedures and/or supplies, which can reasonably be expected to result in the same or better care of the Member. The Member, in accepting the recommendations, agrees to hold Underwriters harmless and Underwriters shall not be held liable or otherwise responsible for any treatment, service, supply, procedure or care provided to the Member except for the payment of benefits under this insurance. After the Member has been notified that the claim or diagnosis meets the Patient Advocacy program requirements, Underwriters reserve the rights to:

1. Make payment for treatments, services and/or supplies which are not covered under this insurance which would be beneficial to the Member and cost effective to Underwriters; and
2. Deny payment for expenses which would otherwise be covered under this insurance which are over the amount Underwriters would have paid had the Member followed the recommendations of the Patient Advocacy program.

J. SUBROGATION

Members undertake to cooperate with Underwriters in the prosecution of any and all valid claims they may have against third parties arising out of any occurrence which results or may result in a loss payment by Underwriters and to account for any amounts recovered on the basis that Underwriters shall be entitled to recover first in full any sums paid by them before the Member shares in any amount so recovered. Should the Member fail to prosecute any valid claims against third parties and Underwriters thereupon become liable to make payment under this insurance, then Underwriters shall be subrogated to all rights of the Member. Any amount recovered by Underwriters shall be used to pay the expenses of collection and reimbursement of Underwriters for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts shall be paid to the Member.

K. OTHER INSURANCE

Underwriters shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance, pay such claim. This insurance will apply for expenses in excess of the amount paid or payable under such other insurance. Underwriters shall not pay any claim in respect to care, treatment, services or supplies furnished by any program or agency funded by any government.

L. ASSIGNMENT

The Member may assign benefits under this insurance to a Hospital, Physician or other provider. Any assignment shall not confer upon such Hospital, Physician or other

provider any right or privilege granted to the Member under this insurance except for the right to receive benefits, if any, which are determined to be due and payable hereunder. No Hospital, Physician or other provider shall have any direct or indirect claim or right of action against Underwriters or the Plan Administrator.

M. RIGHT OF RECOVERY

In the event of overpayment of any claim hereunder because:

1. all or some of the expenses were not paid for by or on behalf of the Member or were subsequently recovered by or on behalf of the Member; or
2. any Relative of the Member or any person in the Member's family, whether or not that person is or was a Member, is repaid for all or some of those expenses by a source other than Underwriters; or
3. all or some of the expenses were not Eligible Expenses; or
4. all or some of the expenses were paid or reimbursed based on incorrect benefit application,

Underwriters have the right to recover the amount of overpayment from the Member and/or the Hospital, Physician or other provider of services or supplies. The amount of the recovery is the difference between:

a. the amount of expenses actually paid by Underwriters; and
b. the amount of expenses which should have been paid by Underwriters.

If the Member or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to Underwriters, Underwriters may, in addition to any other remedies available to them, either:

1. reduce the amount of any future claim that is otherwise eligible for payment hereunder, to the full extent of the refund due Underwriters; or
2. cancel the Certificate issued to the Member by giving 30 days advance written notice by mail to the Member's last known address.

N. CLAIMS ASSISTANCE

Every attempt will be made to help Members understand the benefits provided by this insurance, however, any statement made by an employee of Underwriters or the Plan Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time proper and complete Proof of Claim is submitted and all facts are presented in writing. If a definite answer to a specific question is required, the Member can submit a written request, including all pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent to the Member and kept on file.

ARTICLE 4 – MEMBER ELIGIBILITY

In order to be eligible for insurance hereunder, the person must:

A. Complete and sign an Application with all questions answered truthfully; and
B. Pay the required Premium on or before the Due Dates; and
C. Receive written acceptance of the Application or Renewal from Underwriters; and
D. Be at least 14 days old; and
E. Be under the age of 75, unless the initial Certificate Effective Date was prior to the Member's 65th birthday;

F. If a US citizen, must be located outside the US at time of Application or Renewal or depart from the US not more than 30 days after the initial Certificate Effective date or renewal Effective date and reside outside the US for at least 6 months; or

G. If not a US citizen, must be located outside the US at time of Application or Renewal or depart from the US not more than 30 days after the initial Certificate Effective date or renewal Effective date and reside outside the US for at least 6 months; or

H. If not a US citizen but located in the US at time of Application or Renewal, must not be eligible for any other medical insurance plan which is available to individuals similarly situated in the US from US insurers; and

I. Not be Pregnant, Hospitalized or Disabled on the initial Certificate Effective date; and

J. Not be HIV+ on the initial Certificate Effective date.

ARTICLE 5 – CERTIFICATE EFFECTIVE DATE

Coverage hereunder with respect to a Member shall become effective at 12:01am US Eastern Standard Time on the date specified by Underwriters and indicated on the Declaration attached to the Certificate issued to the Member.

ARTICLE 6 – TERMINATION OF COVERAGE FOR MEMBERS

Coverage hereunder with respect to a Member shall terminate effective the earliest of the following dates:

A. 12:01am US Eastern Standard Time on the last day for which Premium has been paid; or

B. 12:01am US Eastern Standard Time twelve (12) months following the Effective date indicated on the Declaration attached to the Certificate issued to the Member; or

C. 12:01am US Eastern Standard Time on the date the Member no longer meets the Member Eligibility requirements set forth in Article 4 herein; or

D. 12:01am US Eastern Standard Time on the 30th day after the Certificate Effective date if the Member is a citizen of the US and located in the US at time of Application for this insurance and has not departed the US; or

E. 12:01am US Eastern Standard Time on the first day following 6 months cumulative time spent in the US in a Certificate Period if the Member is a citizen of the US; or

F. 12:01am US Eastern Standard Time on the 30th day after the Certificate Effective date if the Member is not a citizen of the US but is located in the US at the time of Application for this insurance and has not departed the US, unless the Member is not eligible for any other medical insurance plan which is available to individuals similarly situated in the US from US insurers; or

G. 12:01am US Eastern Standard Time on the first day following 6 months cumulative time spent in the US in a Certificate Period if the Member is not a citizen of the US and is eligible for another medical insurance plan available to individuals similarly situated in the US from US insurers; or

H. The date and time Underwriters, at their sole option, elect to cancel all Members of the same sex, age, class or geographic location of the Member, provided Underwriters give no less than 30 days advance written notice by mail to the Member's last known address; or

I. The Cancellation Date specified by Underwriters pursuant to Article 7 – CANCELLATION BY MEMBER.

ARTICLE 7 – CANCELLATION BY MEMBER

The Member may request Cancellation of insurance hereunder by giving Underwriters not less than 60 days advance written request. Cancellation is at the option of Underwriters. If Underwriters grant Cancellation, coverage shall terminate with effect from the Cancellation Date specified by Underwriters. Underwriters shall calculate the Short Rate Earned Premium in accordance with the Short Rate Cancellation Table For Term of One Year, set forth in form SLC3(USA). If the Member has paid more than the Short Rate Earned Premium, Underwriters shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Member has paid less than the Short Rate Earned Premium, the Member shall remit to Underwriters the difference between the Short Rate Earned Premium and the amount actually paid.

ARTICLE 8 – REINSTATEMENT OF INSURANCE FOR MEMBER

In the event insurance with respect to a Member is terminated in accordance with Article 6 or cancelled in accordance with Article 7, the Member may apply to Underwriters for Reinstatement. Reinstatement is at the option of Underwriters. In order to be considered for Reinstatement, the Member must submit all of the following to Underwriters:

A. A written request for Reinstatement; and
B. A completed Application for Reinstatement; and
C. A written statement giving full details, as requested by Underwriters, of any claims incurred by the Member since the termination date; and
D. Payment of all Premiums due (including Reinstatement fee, if applicable).

If Underwriters grant Reinstatement, they will promptly inform the Member, and Reinstatement shall be effective as of the termination date or cancellation date. If Underwriters do not grant Reinstatement, their sole obligation shall be to return any balance due to the Member.

ARTICLE 9 – SCHEDULE OF BENEFITS AND LIMITS

Benefit	**Limit**
Coverage Area	Worldwide including the US and Canada
Deductibles	$250, $500, $1,000, $2,500 or $5,000 per Member per Certificate Period
Family Deductible	Maximum of 3 Deductibles per Family per Certificate Period
Coinsurance – Claims incurred in US or Canada	Underwriters will pay 80% of the next $5,000 of Eligible Expenses per Member after the Deductible, then 100% to the Overall Maximum Limit. The Coinsurance will be waived if expenses are incurred within the PPO and expenses are submitted to Underwriters for review and payment directly to the provider

Coinsurance – Claims incurred outside US or Canada	Underwriters will pay 100% of Eligible Medical Expenses after the Deductible to the Overall Maximum Limit
Family Coinsurance Maximum	After $3,000 of Coinsurance has accumulated per Family in a Certificate Period, Underwriters will pay 100% of Eligible Expenses to the Overall Maximum Limit
Hospital Room and Board – In US or Canada	Average Semi-private room rate, including nursing services
Hospital Room and Board – Outside US or Canada	Average Private room rate, including nursing services
Intensive Care Unit – In US or Canada	Usual, Reasonable and Customary
Intensive Care Unit – Outside US or Canada	Usual, Reasonable and Customary
Mental Health Disorders	$10,000 per Certificate Period (after 12 months of continuous coverage); $25,000 Lifetime Maximum. $50 per visit maximum for outpatient care
Maternity – Normal or Complicated Delivery	After the Deductible, Underwriters will pay 50% of the next $100,000 of Eligible Medical Expenses, then 100% to a Lifetime Maximum of $250,000. Covered Maternity expenses include pre-natal, Delivery, and post-natal care (after 12 months of continuous coverage)
Maximum for Maternity	$250,000 Lifetime
Newborn Care	Included as part of Maternity benefits for a maximum of 60 days
Pre-existing Conditions	Same as any other Injury or Illness if disclosed on Application and not excluded or limited by Rider
Local Ambulance	Usual, Reasonable and Customary charges when covered Illness or Injury results in hospitalization as Inpatient
Physical Therapy/Chiropractic Care	$50 Maximum per visit
Wellness	All Wellness benefits are available after 12 months of continuous coverage and are not subject to Deductible. Members under age 19: $50 per visit (including immunizations), maximum of 3 visits per Certificate Period. Members age 30 and older: $250 per Member per Certificate Period. Female Members age 40 and older (or qualifying Woman at Risk as herein defined): $100 per Member per Certificate Period for a mammography screening

Human Organ/Tissue Transplants	Same as any other Illness for Covered Transplants
Emergency Medical Evacuation	$50,000 Lifetime Maximum
Repatriation of Remains	$25,000 Limit, per Member
Emergency Reunion	$10,000 Lifetime Maximum
Pre-certification Penalty	50%
Overall Maximum Limit	$5,000,000 Lifetime

ARTICLE 10 – PRE-CERTIFICATION REQUIREMENTS

A. The following expenses must always be Pre-certified:
   1. Inpatient care; and
   2. any Surgery or Surgical Procedure; and
   3. care in an Extended Care Facility; and
   4. Home Nursing Care; and
   5. Durable Medical Equipment; and
   6. artificial limbs; and
   7. Computerized Tomography (CAT Scan); and
   8. Magnetic Resonance Imaging (MRI); and
   9. Maternity (see special requirements in B.2. of this section); and
   10. Newborn care; and
   11. Human Organ/Tissue Transplants.

B. To comply with the Pre-certification requirements, the Member must:
   1. Contact the Plan Administrator at the telephone number contained in the Member's Certificate as soon as possible before the expense is to be incurred; and
   2. If Pre-certification is for Maternity, contact the Plan Administrator at the telephone number contained in the Member's Certificate as soon as possible but always
      a. during the first 90 days of Pregnancy, and
      b. immediately upon any change in status during Pregnancy, and
      c. upon admission to a Hospital for Delivery; and
   3. Comply with the instructions of the Plan Administrator and submit any information or documents they require; and
   4. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Plan Administrator.

C. If the Member complies with the Pre-certification requirements, and the expenses are Pre-certified, Underwriters will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions herein. If the Member does not comply with the Pre-certification requirements or if the expenses are not Pre-certified:
   1. Eligible Medical Expenses will be reduced by 50%; and
   2. The Deductible will be subtracted from the remaining amount; and
   3. The Coinsurance will be applied.

D. Emergency Pre-certification: In the event of an Emergency Hospital admission, Pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.

E. Pre-certification Does Not Guarantee Benefits – The fact that expenses are Pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.

F. Concurrent Review – For Inpatient stays of any kind, the Plan Administrator will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if a Member receives prior approval.

ARTICLE 11 – UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO) REQUIREMENTS

Nothing contained in this insurance restricts or interferes with the Members' right to select the Hospital, Physician or other medical service provider of the Members choice. Nothing contained in this insurance restricts or interferes with the relationship between the Member and the Hospital, Physician or other providers with respect to treatment or care of any condition, nor the right of any Member to receive, at his or her own expense, services and/or supplies that are not covered under this insurance.

To comply with the United States Preferred Provider Organization requirements, the Member must receive medical treatment from PPO providers while in the United States. If the Member chooses to seek treatment from a PPO provider, Underwriters will remit payment for eligible expenses directly to the provider and will waive the Coinsurance applicable to the expenses. Notwithstanding the foregoing, Transplant benefits are payable only when expenses are incurred in PPO providers.

Members may review a listing of Hospitals, Physicians and other medical service providers included in the PPO Network for the area where the Member will be receiving treatment by accessing the Internet website for HCC Medical Insurance Services at: www.hccmis.com.

ARTICLE 12 – ELIGIBLE EXPENSES

A. ELIGIBLE MEDICAL EXPENSES

Subject to the Deductible, Coinsurance, Limits, geographical and coverage requirements set forth in the ARTICLE 9 – SCHEDULE OF BENEFITS AND LIMITS, Underwriters will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   a. Daily room and board and nursing services not to exceed the amount and duration specified in the Schedule of Benefits and Limits; and
   b. Daily room and board and nursing services in Intensive Care Unit not to exceed the amount and duration specified in the Schedule of Benefits and Limits; and
   c. Use of operating, treatment or recovery room; and
   d. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients; and
   e. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   f. Emergency treatment of an Illness; however, charges for use of the emergency room itself will not be covered unless the Member is

directly admitted to the Hospital as Inpatient for further treatment of that Illness.

2. For Surgery at an Outpatient surgical facility, including services and supplies.
3. For charges made by a Physician for professional services, including Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual, Reasonable and Customary charge of the primary surgeon, but standby availability will not be deemed to be a professional service and therefore not covered hereunder.
4. For dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Physician, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices and supplies for repeat use at home except Durable Medical Equipment as defined herein.
5. For diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, competency, behavioral and educational testing are not included).
6. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, but not the replacement or repair thereof.
7. For Reconstructive Surgery when the Surgery is directly related to Surgery or Accident which is covered hereunder. For the purpose of this coverage, Reconstructive Surgery means Surgery performed on abnormal body structures caused by trauma, infection, tumors or disease to correct adverse physical effects. Reconstructive Surgery will also include breast Reconstructive Surgery following a covered mastectomy and skin grafts following a covered Accident.
8. For radiation therapy or treatment and chemotherapy.
9. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
10. For oxygen and other gasses and their administration by or under the supervision of a Physician.
11. For anesthetics and their administration by a Physician.
12. For drugs which require prescription by a Physician for treatment of a covered Injury or Illness, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of 60 days per prescription.
13. For care in a licensed Extended Care Facility upon direct transfer from an acute care Hospital.
14. Home Nursing Care in bed by a qualified licensed professional, provided by a Home Health Care Agency upon direct transfer from an acute care Hospital and only in lieu of Medically Necessary Inpatient hospitalization.
15. Emergency Local Ambulance transport necessarily incurred in connection with a covered Injury or Illness resulting in Inpatient Hospitalization.
16. Emergency Dental Treatment and Dental Surgery necessary to restore or replace sound natural teeth lost or damaged in an Accident which was covered hereunder.

17. For routine and Medically Necessary care of Newborns during the first 60 days of life provided the delivery of the Newborn is covered hereunder.
18. Expenses incurred as a result of Pregnancy, childbirth, miscarriage, or any complications arising therefrom, except certain maternity testing may not be covered. The following maternity routine tests and screening exams may be payable if all of the terms and conditions of the Certificate are met: a pregnancy test, CBC, Hepatitis B, surface antigen, Rubella screen, toxoplasmosis, blood typing ABO, RH blood antibody screen, urinalysis, urine bacterial culture, microbial nucleic acid probe, pap smear, and glucose challenge test (at 24 - 28 weeks gestation), two ultrasounds (subsequent ultrasounds only if they are ordered by a Physician as Medically Necessary and if a claim is submitted with the pregnancy record and ultrasound report confirming the Medical Necessity). Pre-natal vitamins are not covered. Genetic testing, including but not limited to nuchal translucency screening (NTS) and chorionic villus sampling (CVS), is not covered. For Pregnancy expenses incurred within the US, the Physician should bill prenatal care at the time of delivery in the Global billing format, utilizing current CPT - globally accepted billing practices.
19. For Mental Health Disorders when treated by a Physician.
20. For charges for physical therapy performed by a professional physical therapist, prescribed by a Physician who is not affiliated with the physical therapy practice, necessarily incurred to continue recovery from a covered Injury or Illness.
21. Medically Necessary rental of Durable Medical Equipment (consisting of a standard basic hospital bed and or a standard basic wheelchair) up to the purchase prices.
22. The following Wellness expenses for Members age 30 and above (following 12 months of continuous coverage under this plan): One Routine Physical Exam per Certificate Period provided that at least 12 months has elapsed since the last Routine Physical Exam. For female Members, Routine Physical Exam includes expenses for pap smears.
23. The following Wellness expenses for female Members age 40 and over as well as for female Members qualifying as a Woman at Risk as herein defined (following 12 months of continuous coverage under this plan): One screening mammogram per Certificate Period provided that at least 12 months has elapsed since the last screening mammogram.
24. The following Wellness expenses for Members age 18 and under (following 12 months of continuous coverage under this plan): Up to 3 Physician office visits per year for Routine Physical Exams (including immunizations).
25. The following Human Organ/Tissue Transplant-related expenses:
    Underwriters will pay Eligible Medical Expenses for the Covered Transplants, in addition to the following expenses, but always subject to the Limits set forth in the Schedule of Benefits and Limits:
    a. Eligible Medical Expenses incurred by a live donor will be treated as if they were the expenses of the Member receiving the Transplant if the Member received an organ or tissue of the live donor; and

b. Organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a Lifetime Maximum of $10,000; and

c. Reasonable travel and lodging expenses of the Member if travel of more than 100 miles is necessary to receive Transplant treatment and services, up to a Lifetime Maximum of $5,000.

B. ELIGIBLE EMERGENCY MEDICAL EVACUATION EXPENSES

Subject to the Deductible, Coinsurance, Limits, geographical and coverage requirements set forth in the ARTICLE 9 – SCHEDULE OF BENEFITS AND LIMITS, and subject to the Conditions and Restrictions contained in this provision, Underwriters will pay the following expenses incurred while this insurance is in effect:

1. Emergency air transportation to a suitable airport nearest to the Hospital where the Member will receive treatment; and
2. Emergency ground transportation necessarily preceding Emergency air transportation; and from the destination airport to the Hospital where the Member will receive treatment.

Conditions and Restrictions:

a. The Member must be in compliance with all conditions and provisions of this insurance; and

b. Underwriters will provide Emergency Medical Evacuation benefits only when the Illness or Injury giving rise to the Emergency Medical Evacuation is covered under this Insurance; and

c. Underwriters will provide Emergency Medical Evacuation benefits only when all of the following conditions are met:
   i. Medically Necessary treatment, services and supplies cannot be provided locally; and
   ii. Transportation by any other method would result in loss of Member's life or limb; and
   iii. Recommended by the attending Physician who certifies to the above; and
   iv. Agreed upon by the Member or a Relative of the Member; and
   v. Approved in advance and coordinated by Underwriters; and
   vi. The condition giving rise to the Emergency Medical Evacuation occurred spontaneously and without advance warning, either in the form of Physician recommendation or symptoms which would have caused a prudent person to seek medical attention prior to the onset of the Emergency.

d. Underwriters will provide Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary treatment, services and supplies to prevent the Member's loss of life or limb.

e. Underwriters will use their best efforts to arrange any Emergency Medical Evacuation within the least amount of time possible. The Member understands that the timeliness of Emergency Medical Evacuation can be affected by circumstances which are not within

the control of Underwriters such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. The Member agrees to hold Underwriters harmless and Underwriters shall not be held liable for any delays that are not within their direct and immediate control.

C. ELIGIBLE REPATRIATION OF REMAINS EXPENSES

Subject to the Deductible, Coinsurance, Limits, geographical and coverage requirements set forth in the ARTICLE 9 – SCHEDULE OF BENEFITS AND LIMITS, and subject to the conditions and Restrictions contained in this provision, Underwriters will pay the following expenses incurred while this insurance is in effect arising from the death of a Member:

1. Air or ground transportation of bodily remains or ashes to the airport or ground transportation terminal nearest to the Principal Residence of the deceased Member; and
2. Reasonable costs of preparation of the remains necessary for transportation.

Conditions and Restrictions:

a. The Member must be in compliance with all conditions and provisions of this insurance; and
b. Repatriation of Remains must be approved in advance and coordinated by Underwriters; and
c. Underwriters will provide Repatriation of Remains benefits only when the death of the Member occurs as a result of an Injury or Illness that is covered under this insurance; and
d. Underwriters will provide Repatriation of Remains benefits only when the Death of the Member occurs while this insurance is in effect; and
e. Underwriters will use their best efforts to arrange any Repatriation of Remains within the least amount of time possible. The Member understands that the timeliness of Repatriation can be affected by circumstances which are not within the control of Underwriters such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. The Member, and his/her heirs, agree to hold Underwriters harmless and Underwriters shall not be held liable for any delays which are not within their direct and immediate control. Further, Underwriters are held harmless and shall not be held liable for loss of or any damage or other impairment to bodily remains incurred during the Repatriation process or otherwise.

D. ELIGIBLE EMERGENCY REUNION EXPENSES

Subject to the Deductible, Coinsurance and Limits set forth in ARTICLE 9 – SCHEDULE OF BENEFITS AND LIMITS, and subject to the Conditions and Restrictions contained in

this provision, Underwriters will pay the following Emergency Reunion expenses, following a covered Emergency Medical Evacuation under this insurance:

1. The cost of an economy round trip air or ground transportation ticket for one Relative of the Member for transportation to the terminal serving the area where the Member is Hospitalized or is to be Hospitalized following Emergency Medical Evacuation; and
2. Reasonable expenses for lodging and meals for the Relative, which are incurred in the area where the Member is hospitalized for a period not to exceed 15 days.

Conditions and Restrictions:

a. The Member must be in compliance with all conditions and provisions of this insurance; and
b. Emergency Reunion must be approved in advance and coordinated by Underwriters; and
c. Underwriters will provide Emergency Reunion Benefits only following an Emergency Medical Evacuation of a Member that is covered hereunder.

ARTICLE 13 – WAR, TERRORISM, BIOLOGICAL, CHEMICAL, NUCLEAR EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement or rider attached hereto, it is agreed that this insurance excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss, damage, cost or expense:

1. war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; and
2. the use of any biological, chemical, radioactive or nuclear agent, material, device or weapon; however, this exclusion shall not apply where the Member is exposed to nuclear radioactive and/or radioactive material for the purpose of medical treatment; and
3. any Act of Terrorism.

For the purpose of this insurance, an "Act of Terrorism" means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This insurance also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to (1), (2) or (3) above.

If Underwriters allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance, the burden of proving the contrary shall be upon the Member.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

ARTICLE 14 – OTHER EXCLUSIONS

The following charges, treatments, care, services, supplies and/or conditions are excluded from coverage hereunder:

1. Pre-existing Conditions – Charges that result directly or indirectly from:
   a. Any Pre-existing Condition, as herein defined, that is not fully disclosed on the Member's Application. Non-disclosure of any Pre-existing Condition may render this insurance null and void in accordance with ARTICLE 3 – CONDITIONS PRECEDENT, B. MISREPRESENTATION AND FRAUD.
   b. Any Injury, Illness, or Mental Health Disorder that manifests on or after the date of Application and prior to the Certificate Effective Date.
   c. Any Accident that occurs on or after the date of Application and prior to the Certificate Effective Date.
2. Special Illnesses – Charges for treatment of the following Illnesses or conditions which manifest themselves and/or procedures which take place and/or are recommended during the first 180 days of coverage hereunder beginning on the initial Certificate Effective Date: any condition of the breast, prostate, the reproductive system, tonsils, adenoids, hemorrhoids, hernia, gallstones, kidney stones, glaucoma, cataracts, disk disease, varicose veins, all types of cysts, arthritis, and repetitive motion disorders, and any disorder or disease of the skin.
3. Maternity: Charges related directly or indirectly to Pregnancy, including pre-natal care, delivery and post-natal care, are excluded from this insurance until the Member has maintained coverage hereunder continuously for 12 months.
4. Genetic medicine or genetic testing, including without limitation amniocentesis, genetic screening, risk assessment, prevention and/or pre-disposition determination, genetic counseling and/or gene therapy.
5. Charges for routine and Medically Necessary care of newborns are excluded unless the Delivery of the newborn is covered hereunder.
6. Charges for routine and Medically Necessary care of newborns after the first 60 days of life.
7. Congenital conditions, except this exclusion does not apply to newborns when the Delivery of the newborn is covered hereunder.
8. Mental Health Disorders: Charges for treatment of Mental Health Disorders are excluded from this insurance until the Member has maintained coverage hereunder continuously for 12 months.
9. Wellness: Charges for Routine Physical Exams are excluded from this insurance until the Member has maintained coverage hereunder continuously for 12 months, and for all Members who are between the ages of 18 and 30. In no event will Underwriters pay Wellness benefits for more than one Routine Physical Exam during any 12 month period for Members age 30 and over, one screening

mammogram during any 12 month period for female Members age 40 and over or qualifying as a Woman at Risk, or three Routine Physical Exams during any 12 month period for Members under the age of 19.

10. Charges which are not Incurred by a Member during his/her Certificate Period.
11. Charges for any benefit hereunder which are not presented to Underwriters for payment within 60 days beginning on the last day of the Certificate Period.
12. Treatment, services or supplies which are not administered by or under the supervision of a Physician.
13. Treatment, services or supplies which are not Medically Necessary, as herein defined.
14. Treatment, services or supplies provided at no cost to the Member.
15. Charges which exceed Usual, Reasonable and Customary, as herein defined.
16. Telephone consultations or failure to keep a scheduled appointment.
17. Surgeries, treatments, services or supplies which are Investigational, Experimental or for Research Purposes.
18. All charges Incurred while the Member is confined primarily to receive Custodial Care, Educational or Rehabilitative Care.
19. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass Surgery.
20. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Member such as sex-change Surgery.
21. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is directly related to and follows a Surgery which was covered hereunder.
22. Treatment of Members who were HIV+ at their initial Certificate Effective Date, whether or not the Member had knowledge of his/her HIV status.
23. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
24. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
25. Growth Hormone treatment.
26. Dental Treatment, except for Emergency Dental Treatment necessary to replace sound natural teeth lost or damaged in an Accident covered hereunder.
27. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices and all vision and hearing tests and examinations.
28. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
29. Treatment of the temporomandibular joint.
30. Injury resulting from participation in the following activities:
    a. Amateur Athletics, Contact Sports, and professional sports or athletic activities. Non-contact and non-organized/non-sanctioned amateur sports or athletic activities engaged in by the Member solely for leisure, recreational, entertainment or fitness purposes are not excluded unless they are excluded by (b) through (j) of this provision; and
    b. mountaineering where ropes or guides are normally used or at elevations of 4,500 meters or higher; and

c. aviation (except when traveling solely as a passenger in a commercial aircraft); and
d. hang gliding, sky diving, parachuting or bungee jumping; and
e. snow skiing or snowboarding, except for recreational downhill and/or cross country snow skiing or snowboarding (no cover provided whilst skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body); and
f. racing by any animal or motorized vehicle; and
g. spelunking; and
h. subaqua pursuits involving underwater breathing apparatus unless PADI/NAUI certified, accompanied by a certified instructor, and at depths of less than 10 meters; and
i. jet skiing; and
j. any other sport or athletic activity which is undertaken for thrill seeking and exposes the Member to abnormal or extraordinary risk of Injury.

31. Injury sustained while under the influence of or due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with treatment prescribed and directed by a Physician but not for the treatment of Substance Abuse.
32. Willfully self-inflicted Injury or Illness.
33. Venereal disease, including all sexually transmitted diseases or conditions.
34. Willful and/or therapeutic termination of Pregnancy.
35. Immunizations and Routine Physical Exams except for Newborns under the age of 60 days and except for the Wellness expenses provided for herein.
36. Treatment by a chiropractor unless Medically Necessary and ordered in advance by a doctor of Medicine (MD) who is not affiliated with the chiropractor or chiropractic practice.
37. Charges resulting from or occurring during the commission of a violation of law by the Member, including without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.
38. Treatment of Substance Abuse.
39. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.
40. Any services or supplies performed or provided by a Relative of the Member or any family Member of the Member or any person who ordinarily resides with the Member.
41. Orthoptics and visual eye training.
42. Services or supplies which are not included as Eligible Expenses as described herein.
43. The following care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
44. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
45. Treatment of sleep disorders.
46. Exercise programs, whether or not prescribed or recommended by a Physician.

47. Treatment required as a result of complications or consequences of a treatment or condition not covered hereunder.
48. Charges for travel or accommodations, except as provided for in the Local Ambulance, Emergency Medical Evacuation, and Human Organ/Tissue Transplant sections of this insurance.
49. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
50. Human Organ or Tissue Transplants or related services, except for Covered Transplants.
51. Artificial or mechanical devices designed to replace human organs temporarily or permanently.
52. Expenses to keep a donor alive for a transplant procedure, whether or not the transplant procedure is a Covered Transplant.
53. Transplant benefits for more than one Covered Transplant during any 12 month period, except re-transplantation if during initial transplant procedure.

ARTICLE 15 – DEFINITIONS

Accident: A sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in physical Injury to the Member.

AIDS: Acquired Immune Deficiency Syndrome as that term is defined by the United States Centers for Disease Control.

ARC: AIDS Related Complex as that term is defined by the United States Centers for Disease Control.

Amateur Athletics: A sport or other athletic activity that is organized and/or sanctioned, involving regular or scheduled practices and/or regular or scheduled games. This definition does not include athletic activities that are non-contact and engaged in by a Member solely for recreational, entertainment or fitness purposes and not for wage, reward or profit.

Application: The fully answered and signed Application for Insurance which is attached to the Certificate issued to the Member.

Assured: The Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda.

Certificate: The document issued to the Member which provides evidence of benefits payable under the Master Policy, and which includes the Member's Application for Insurance.

Certificate Period: The twelve month period of time beginning on the Certificate Effective date, both days at 12:01am US Eastern Standard Time.

Coinsurance: The payment by the Member of Eligible Expenses at the percentage specified in the Schedule of Benefits and Limits.

Complicated Delivery: A Pregnancy that results in or is expected to result in delivery by Cesarean Section, provided such Cesarean Section is Medically Necessary.

Contact Sports: A sport or other athletic activity that necessarily involves physical contact with opposing players as part of normal play. Contact Sports include but are not limited to American football, boxing, ice hockey, rugby, soccer, and wrestling.

Covered Transplant: Heart, Heart/Lung, Lung, Kidney, Kidney/Pancreas, Liver, and Allogenic and Autologous Bone Marrow.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Member in performing the activities of daily

living. Custodial Care also includes nonacute care for the comatose, semicomatose, paralyzed or mentally incompetent patient.

Declaration: The Declaration is attached to and forms a part of this Certificate.

Deductible: The dollar amount of Eligible Expenses, specified in the Schedule of Benefits and Limits, that the Member must pay per Certificate Period.

Dental Treatment: The care of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

Disabled: A person who has a congenital or acquired mental or physical defect that interferes with normal functioning of the body system or the ability to be self-sufficient.

Durable Medical Equipment: A standard basic hospital bed and/or a standard basic wheelchair.

Educational or Rehabilitative Care: Care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to, vocational or occupational therapy and speech therapy.

Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Member's life or limb in danger if medical attention is not provided within 24 hours.

Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a Hospital, Extended Care Facility or rehabilitation facility by the state in which it operates; and is regularly engaged in providing 24 hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a Physician; and provides each patient with active treatment of an Illness or Injury. Extended Care Facility does not include a facility primarily for rest, the aged, Substance Abuse treatment, Custodial Care, nursing care or for care of Mental Health Disorders or the mentally incompetent.

Family: The individual(s) shown on the Declaration attached to this Certificate.

HIV+: Laboratory evidence defined by the United States Centers for Disease Control as being positive for Human Immunodeficiency Virus infection.

Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse, and maintains a daily record on each patient, and provides each patient with a planned program of observation and treatment by a Physician.

Home Nursing Care: Services provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient, provided always that such care is provided in lieu of Medically Necessary Inpatient care in a Hospital.

Hospital: An institution which operates as a hospital pursuant to law, and is licensed by the State or Country in which it operates; and operates primarily for the reception, care and treatment of sick or injured persons as Inpatients; and provides 24-hour nursing service by Registered Nurses on duty or call; and has a staff of one or more Physicians available at all times; and provides organized facilities and equipment for diagnosis and treatment of acute medical conditions on its premises; and is not primarily a long-term care facility, Extended Care Facility, nursing, rest, Custodial Care or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

Illness: A sickness, disorder, illness, pathology, abnormality, ailment, disease or any other medical, physical or health condition. Illness does not include learning disabilities, attitudinal disorders or disciplinary problems.

Incurred: A charge is incurred on the date the service is provided or the supply is purchased.

Injury: Bodily Injury resulting from an Accident.

Inpatient: A person who is an overnight resident patient of a Hospital, using and being charged for room and board.

Intensive Care Unit: A Cardiac Care Unit or other unit or area of a Hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Investigational, Experimental or for Research Purposes: Terms used to describe procedures, services or supplies that are by nature or composition, or are used or applied, in a way which deviates from generally accepted standards of current medical practice.

Medically Necessary: A service or supply which is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice as determined by Underwriters. A service or supply will not be considered Medically Necessary if is provided only as a convenience to the Member or provider, and/or is not appropriate for the Member's diagnosis or symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment of an Illness or Injury.

Member: An individual who is covered under this insurance.

Mental Health Disorder: A mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. Mental Health Disorders include: psychosis, depression, schizophrenia, bipolar affective disorder, and those psychiatric illnesses listed in the current edition of the diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Normal Delivery: A Pregnancy that results in or is expected to result in a vaginal delivery.

Outpatient: A Member who receives Medically Necessary treatment by a Physician for Injury or Illness that does not require overnight stay in a Hospital.

Physician: A doctor of Medicine (MD), doctor of Dental Surgery (DDS), doctor of Dental Medicine (DDM), doctor of Podiatry (DPM), doctor of Osteopathy (DO), doctor of Chiropractic (DC), a licensed Physical Therapist or Physiotherapist, and a doctor of Psychiatry (Psy.D) and a doctor of Psychology (Ph.D). Physician also includes a Certified Nurse Practitioner (CNP) under the direction of a Medical Doctor for Outpatient services. A Physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license.

Plan Administrator: HCC Medical Insurance Services, 251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204, Telephone (317) 262-2132, Fax (317) 262-2140.

Preferred Provider Organization (PPO): The network of Physicians, Hospitals and other medical service providers under contract with the Plan Administrator.

Pre-existing Condition: Any Injury, Illness or Mental Health Disorder which existed at the initial Certificate Effective Date and/or any chronic or recurring Illness and/or chronic or recurring Mental Health Disorder which existed at or prior to the initial Certificate

Effective Date. Pre-existing Condition also includes any chronic, subsequent or recurring complications or consequences associated with these conditions.

Pregnancy: The physical condition of being pregnant.

Proof Of Claim: A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments, original itemized bills from Physicians, Hospitals and other medical providers, original receipts for any expenses which have already been paid by or on behalf of the Member, and any other documentation that is deemed necessary by the Underwriters.

Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N" after his or her name.

Relative: Biological, adopted or step parent(s), current spouse, biological, adopted or stepsibling(s), and biological, adopted or step child(ren).

Routine Physical Exam: Examination of the physical body by a Physician for preventative or informative purposes only, and not for the diagnosis or treatment of any condition.

Substance Abuse: Alcohol, drug or chemical abuse, overuse or dependency.

Surgery or Surgical Procedure: An invasive diagnostic procedure; or the treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

US: The United States of America including all states, districts, and possessions.

Usual, Reasonable and Customary: The most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are Reasonable. What is defined as Usual, Reasonable and Customary Charges will be determined by Underwriters. In determining whether a charge is Usual, Reasonable and Customary, Underwriters may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the Illness or Injury being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors as Underwriters, in the reasonable exercise of discretion, determine are appropriate.

Woman at Risk: A woman between the ages of 30 and 39, inclusive, who meets at least one of the following descriptions: (1) has a personal history of breast cancer, (2) has a personal history of breast disease that was proven benign by biopsy, or (3) has a mother, sister or daughter who has had breast cancer.

ARTICLE 16 – HOW TO FILE A CLAIM

Notice of Claim, Claimant's Statement and Authorization and Proof of Claim must be mailed to:

HCC Medical Insurance Services
P.O. Box 863
Indianapolis, Indiana 46206