SERFF Tracking #: BCSF-130097000 State Tracking #:

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Filing at a Glance

Company: 4 Ever Life Insurance Company

Product Name: Group Major Medical - Ex-Pat (Rates)

State: VermontGMCB

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002C Large Group Only - Other

Filing Type: GMCB Rate
Date Submitted: 06/03/2015

SERFF Tr Num: BCSF-130097000
SERFF Status: Pending State Action

State Tr Num:

State Status:

Co Tr Num: 54.1201 VT (EX-PAT RATES)

Implementation On Approval

Date Requested:

Author(s): Sharon Mathews, Susan Hiller, Pallavi Shah

Reviewer(s): Thomas Crompton (primary), Kelly Macnee, Judith Henkin

Disposition Date:
Disposition Status:
Implementation Date:

State Filing Description:

SERFF Tracking #: BCSF-130097000 State Tracking #:

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

General Information

Project Name: Group Major Medical - Ex Pat (Rates)

Status of Filing in Domicile: Authorized

Project Number: 54.1201 VT (Ex-Pat Rates)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments: Rates are available for use in our

DA state of Illinois

Explanation for Combination/Other: Market Type: Group

Submission Type: Resubmission Previous Filing Number: BCSF-129684270

Group Market Size: Large Group Market Type: Employer

Overall Rate Impact: Filing Status Changed: 06/18/2015

State Status Changed:

Deemer Date: Created By: Pallavi Shah

Submitted By: Pallavi Shah Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

This is our resubmission of a initial rate filing and manual for use with our Global Healthguard (Ex-Pat major medical Form 54.1201 VT and related forms) approved under SERFF Tracking #BCSF-127963460. A complete copy of the approved SERFF FORMS filing is attached.

The attached rates and manual are being submitted for review and approval for use with the approved forms. We have provided them in both pdf and Excel format, as requested. The Excel version is attached as a Supporting Document.

The approved Global Health Guard forms provides major medical expense benefits to large employers in the State of Vermont. This coverage is for the benefit of employees (ex-patriates) who are traveling outside the United States for extended periods of time for employer business purposes. It also continues to cover those employees when temporarily back in the United States. A PPO network is used for when a person is state side and uses a Blue Cross / Blue Shield network plan. The carrier provides a list of credentialed providers when an insured is abroad to ensure access to qualified providers. There is no network used and no network differential for providers outside the United States. Coverage is provided for employees and their dependents and is available on a contributory or non-contributory basis. Coverage is available on a guaranteed issue basis to those who enroll.

These rates are new and will not supersede any rates on file with the Department. In addition, please note that SERFF will not allow a "zero" in the number of covered lives field. We were required to put a 1 in that field. This was mentioned as a concern (item 3) in our initial filing, but we are obligated to at least put a 1 in this field.

We trust you will find this submission to be complete.

Company and Contact

Filing Contact Information

Pallavi Shah, Compliance Analyst I pshah@bcsf.com

Company Tracking #: 54.1201 VT (EX-PAT RATES)

SERFF Tracking #: BCSF-130097000 State Tracking #:

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

2 Mid America Plaza 630-472-7873 [Phone]

Suite 200

Oakbrook Terrace, IL 60181

Filing Company Information

4 Ever Life Insurance Company CoCode: 80985 State of Domicile: Illinois

2 Mid America Plaza Group Code: 23 Company Type:
Suite 200 Group Name: State ID Number:

Oakbrook Terrace, IL 60181 FEIN Number: 36-2149353

(630) 472-7842 ext. [Phone]

Filing Fees

Fee Required? Yes

Fee Amount: \$150.00

Retaliatory? No

Fee Explanation:

Check Number Check Amount Check Date

8012285 \$150.00 06/01/2015

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Response Letters

| Status | Created By | Created On | Date Submitted | Responded By | Created On | Date Submitted |
|---------------------|-----------------|------------|----------------|--------------|------------|----------------|
| Pending Response | Thomas Crompton | 06/11/2015 | 06/11/2015 | Pallavi Shah | 06/18/2015 | 06/18/2015 |

Company Tracking #: 54.1201 VT (EX-PAT RATES)

SERFF Tracking #: BCSF-130097000 State Tracking #:

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Objection Letter

Objection Letter Status Pending Response

Objection Letter Date 06/11/2015 Submitted Date 06/11/2015 Respond By Date 06/18/2015

Dear Pallavi Shah, Introduction:

June 11, 2015

Pallavi Shah, Compliance Analyst I 4 Ever Life Insurance Company 2 Mid America Plaza Suite 200 Oakbrook Terrace, IL 60181

RE: SERFF Tracking Number BCSF-130097000

Dear Ms. Shah:

Upon review of the actuarial memorandum and related information the following additional information is needed.

- 1. The "Rate Review Detail" shows \$0.00 annualized PMPM for the minimum, maximum, and weighted average categories. Even though this is an initial rate filing for this product, there must be rate/premium values filled in for these categories.
- 2. Regarding retention, the second table item 8 in the actuarial memorandum, indicates group sizes of 50, 2-399, and 400+. The corresponding table in the rate manual (page 3, section "XV. Retention,") shows group sizes of 1, 2-499, and 400+. Why is there a difference between the two tables? Also, why is there an overlapping group size in the table on page 3 of the rate manual (i.e. "2-499", and "400+")?
- 3. Regarding retention on the second table item 8 in the actuarial memorandum, what does the unlabeled 27.0% represent?
- 4. Regarding "Expenses and Commissions" on the first table item 8 in the actuarial memorandum, the administration charge of 18.5% is high. Provide the calculations (with a breakdown of all component parts) and an explanation of the administration charge. Also, regarding the first submission of this rate filing on 03/04/2015 (which was rejected), the administration charge was shown as 23.5% in item 8 of the actuarial memorandum. Given that this is the same product (Forms 54.1201), explain the difference in the two rate filings between an administration charge of 23.5% and 18.5%.
- 5. Regarding "Expenses and Commissions" on the first table item 8 in the actuarial memorandum, the average commissions of 8.0% is high. Provide the calculations (with a breakdown of all component parts) and an explanation of the average commission charge. Also, since this is an average commission charge, what are the ranges for these charges? Provide an explanation of why there would be different commission charges for this product.
- 6. Regarding "Premium Taxes" of 2.5% on the first table item 8 in the actuarial memorandum, does this include a retaliatory tax?
- 7. Regarding "Contingency and Risk Margin" on the first table item 8 and item 22 in the actuarial memorandum, the contingency and risk margin of 6.0% is high. Provide the calculations (with a breakdown of all component parts) and an explanation for this margin.

SERFF Tracking #: BCSF-130097000 State Tracking #:

Company Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

8. Regarding item 13 "Area Factors" in the actuarial memorandum, it states "rates will vary by zip code and nationality as shown in the rate manual." The rate manual shows, on page 7, area factors by country, but there appears to be no reference to zip code. Explain.

- 9. Regarding item 20 (Minimum Required Loss Ratio) and item 24 (Anticipated Loss Ratio), the current actuarial memorandum shows 65.0%. The first submission of this rate filing on 03/04/2015 (which was rejected), showed an MLR and Anticipated Loss Ratio of 60.0% in the actuarial memorandum. Given that this is the same product (Forms 54.1201), explain the difference in the loss ratios of 65% and 60% between the two filings.
- 10. Provide a signed and dated confirmation by a qualified company actuary that this rate filing is in full compliance with the "Expatriate Health Coverage Clarification Act of 2014."

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than June 18, 2015. We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Since this is the first filing for "4 Ever Life Insurance Company" with the Vermont Green Mountain Care Board (GMCB) we want the company to be informed that the filing procedure is different from the Vermont "Department of Financial Regulation." Please read all the materials on our Rate Review Page at http://ratereview.vermont.gov/how_reviewed.

Note that the Health Care Advocate (HCA) will also be involved with reviewing the filing. The filing will be posted to the GMCB as a public document, and public comments on the filing will also be posted. The filing may require an official hearing with the GMCB, the HCA, the Company, and any other stakeholders.

Please forward this information to your Legal and Actuarial Departments.

If you have any questions, or would like to schedule a phone conference to discuss the contents of this objection letter, please contact either myself or Judith Henkin, Esquire.

Thomas Crompton Senior Health Care Analyst The Green Mountain Care Board (802) 828-2922 thomas.crompton@state.vt.us

Judith Henkin, Esquire Health Policy Director The Green Mountain Care Board (802) 828-1968 Judy.henkin@state.vt.us

Conclusion:

Sincerely, Thomas Crompton

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Response Letter

Response Letter Status Submitted to State

Response Letter Date 06/18/2015 Submitted Date 06/18/2015

Dear Thomas Crompton,

Introduction:

Thank you for your concerns. We have reviewed them and are responding as follows:

Response 1

Comments:

Please see attached objection response letter.

Changed Items:

| Supporting Document Schedule Item Changes | | | | | |
|---|--|--|--|--|--|
| Satisfied - Item: Actuarial Memorandum and Certifications | | | | | |
| Comments: | | | | | |
| Attachment(s): | VT_4EL_ExPat_Act_Memo_revised_20150618.pdf | | | | |
| Previous Version | | | | | |
| Satisfied - Item: | Actuarial Memorandum and Certifications | | | | |
| Comments: | | | | | |
| Attachment(s): | VT_4EL_ExPat_Act_Memo_revised_20150518.pdf | | | | |

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

| dule Item Changes | | | | | |
|---|--|--|--|--|--|
| Item: Actuarial Memorandum and Certifications | | | | | |
| | | | | | |
| chment(s): VT_4EL_ExPat_Act_Memo_revised_20150618.pdf | | | | | |
| | | | | | |
| Actuarial Memorandum and Certifications | | | | | |
| | | | | | |
| VT_4EL_ExPat_Act_Memo_revised_20150518.pdf | | | | | |
| | | | | | |

| Satisfied - Item: | EXCEL COPY - RATE MANUAL |
|-------------------|---|
| Comments: | As requested in closed filing, BCSF-129684270, a copy of the manual in Excel format is required. "All number/calucation type documents within the filing must include the (.xls) version along with the corresponding (.pdf) version" It was unclear if this should be attached to the Rate/Rule tab, so we attached it here. |
| Attachment(s): | VT Expat Rat Manual 2015_06_18.xlsx |
| Previous Version | |
| Satisfied - Item: | EXCEL COPY - RATE MANUAL |
| Comments: | As requested in closed filing, BCSF-129684270, a copy of the manual in Excel format is required. "All number/calucation type documents within the filing must include the (.xls) version along with the corresponding (.pdf) version" It was unclear if this should be attached to the Rate/Rule tab, so we attached it here. |
| Attachment(s): | VT Expat Rate Manual 2015_05_20.xlsx |

SERFF Tracking #: BCSF-130097000 State Tracking #: Company Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

| Supporting Document Schedule Item Changes | | | | | |
|---|--|--|--|--|--|
| Satisfied - Item: | Actuarial Memorandum and Certifications | | | | |
| Comments: | | | | | |
| Attachment(s): VT_4EL_ExPat_Act_Memo_revised_20150618.pdf | | | | | |
| Previous Version | | | | | |
| Satisfied - Item: | Actuarial Memorandum and Certifications | | | | |
| Comments: | | | | | |
| Attachment(s): | VT_4EL_ExPat_Act_Memo_revised_20150518.pdf | | | | |

| Satisfied - Item: | EXCEL COPY - RATE MANUAL | | | |
|--|---|--|--|--|
| Comments: | As requested in closed filing, BCSF-129684270, a copy of the manual in Excel format is required. "All number/calucation type documents within the filing must include the (.xls) version along with the corresponding (.pdf) version" It was unclear if this should be attached to the Rate/Rule tab, so we attached it here. | | | |
| Attachment(s): VT Expat Rat Manual 2015_06_18.xlsx | | | | |
| Previous Version | | | | |
| Satisfied - Item: | EXCEL COPY - RATE MANUAL | | | |
| Comments: | As requested in closed filing, BCSF-129684270, a copy of the manual in Excel format is required. "All number/calucation type documents within the filing must include the (.xls) version along with the corresponding (.pdf) version" It was unclear if this should be attached to the Rate/Rule tab, so we attached it here. | | | |
| Attachment(s): | VT Expat Rate Manual 2015_05_20.xlsx | | | |

| Satisfied - Item: | Objection Response Letter |
|-------------------|---|
| Comments: | |
| Attachment(s): | VT Expat BCSF-130097000 20150611 objection response.pdf |

No Form Schedule items changed.

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

| Rate/Rule Schedule Item Changes | | | | | | | |
|---------------------------------|------------------|---|-------------|----------------------------|--------------------------------------|--------------------------------|--|
| Item No. | Document Name | Affected Form Numbers (Separated with commas) | Rate Action | Rate Action Information | Attachments | Date Submitted | |
| 1 | Rate Manual | Form 54.1201 ER VT | New | | VT Expat Rat Manual 2015_06_18.pdf, | 06/18/2015 By: Pallavi Shah | |
| Previous Version | Previous Version | | | | | | |
| 1 | Rate Manual | Form 54.1201 ER VT | New | | VT Expat Rate Manual 2015_05_20.pdf, | 06/03/2015 By: Pallavi Shah | |

Conclusion:

We appreciate your prompt attention to this filing and look forward to your early approval.

Thank you.

Sincerely,

Pallavi Shah

SERFF Tracking #: BCSF-130097000 State Tracking #:

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Post Submission Update Request Submitted On 06/18/2015

Status: Submitted

Created By: Pallavi Shah

Company Rate Information:

Company Name: 4 Ever Life Insurance Company

| Field Name | Requested Change | Prior Value |
|----------------------------|------------------|-------------|
| REQUESTED RATE: | | |
| Projected Earned Premium: | 519,216.000 | 0.000 |
| Projected Incurred Claims: | 340,086.000 | 0.000 |
| Min: | 432.680 | 0.000 |
| Max: | 432.680 | 0.000 |
| Weighted Avg.: | 432.680 | 0.000 |
| | | |

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Rate Information

Rate data applies to filing.

Filing Method: Review & Approved

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing: Not Applicable

Company Rate Information

| Company Name: | Company Rate Change: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for | Number of Policy Holders Affected for this Program: | Premium for | Maximum % Change (where req'd) | Minimum % Change : (where req'd): |
|-----------------------|----------------------------|-----------------------------------|------------------------------|----------------------------|---|-------------|--------------------------------------|---|
| 4 Ever Life Insurance | New Product | 0.000% | 0.000% | this Program: | 0 | \$0 | 0.000% | 0.000% |
| Company | New Product | 0.000% | 0.000% | \$ 0 | U | \$0 | 0.000% | 0.000% |

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Rate Review Detail

COMPANY:

Company Name: 4 Ever Life Insurance Company

HHS Issuer Id: 00000

PRODUCTS:

| Product Name | HIOS Product ID | HIOS Submission ID | Number of Covered Lives |
|---------------------------------|-----------------|--------------------|-------------------------|
| Major Medical Expense Insurance | | | 1 |

Trend Factors: See Actuarial Memorandum.

Please note that SERFF will not allow a "zero" in the number of covered lives field. We

were required to put a 1 in that field

FORMS:

New Policy Forms: Form 54.1201 ER VT; Form Number 54.1301 ER VT; Form 54.1101 ER

Affected Forms: None Other Affected Forms: None

REQUESTED RATE CHANGE INFORMATION:

Change Period: Other
Member Months: 0
Benefit Change: None

Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 0.00
Total Incurred Claims: 0.00

Annual \$: Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium: 0.00
Projected Incurred Claims: 0.00

Annual \$: Min: 0.00 Max: 0.00 Avg: 0.00

SERFF Tracking #: BCSF-130097000 State Tracking #: Company Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Rate/Rule Schedule

| Ite: No |). I | Schedule Item Status | | Affected Form Numbers (Separated with commas) | Rate Action | Rate Action Information | Attachments |
|------------|------|----------------------------|-------------|---|-------------|-------------------------|-------------------------------------|
| 1 | | | Rate Manual | Form 54.1201 ER VT | New | | VT Expat Rat Manual 2015_06_18.pdf, |

4Ever Life Insurance Company Global HealthGuard Rate Manual Effective 7/1/2015 Table of Contents

| | Page# |
|---|-------|
| I. Benefit Plan Base Rates (See Table A) | 2 |
| II. Usage | 2 |
| III. Premium Cost | 2 |
| IV. Plan Design Factor (See Table B) | 2 |
| V. Relative Geographical Cost (See Table C) | 2 |
| VI. Office Visit Copay Factor | 2 |
| VII. Hospital Out-of-Network Copay Factor | 2 |
| VIII. Medical Evacuation Factor (See Table D) | 2 |
| IX. Integrated Deductible | 2 |
| X. Trend Factors | 2 |
| XI. Anti-Selection Factor | 2 |
| XII. Maximum Benefit Factor | 2 |
| XIII. Group Size Factor | 3 |
| XIV. Age Gender Factors | 3 |
| XV. Retention | 3 |
| XVI. Dental and Vision | 3 |
| XVII. Tier Factors | 3 |
| XVIII. Experience Rating (See Table E) | 3 |
| Sample Rate Calculation | 4 |
| Table A | 5 |
| Table B | 6 |
| Table C | 7 |
| Table D | 8 |
| Table E | 8 |

I. Benefit Plan Base Rates (See Table A)

All plans are compared to the base rate shown in Table AA Claims Premium.

The Medical Base Rate is \$337.00
The Rx Base Rate is \$104.00

The ADD Base Rate is \$0.045 per thousand

II. Usage (split In US in-network, In US out-of-network, Overseas, totals 1.000)

U.S. Citizen Overseas usage: .70

U.S. In-network usage: 5/6 times (1-overseas usage)
U.S. Out-of-network usage: 1/6 times (1-overseas usage)
Overseas usage if an alien traveling aborad: .10

III. Premium Cost:

Base Rate minus A, minus B and coinsurance times C where:

A-Deductible covered claims cost = Deductible divided by .5 if overseas

using deductible covered claims interpolated for interim values

B-Maximum covered claims Cost = [Deductible+minimum(maximum benefit+out-of-pocket; maximum benefit/coinsurance)]/.5 if overseas

using maximum covered claims interpolated for interim values

C-Out-of-pocket covered claims cost = out-of-pocket/(1-coinsurance) (after the deductible covered claims) divided by .5 if overseas

Premium calculated using out-of-pocket covered claims interpolated for interim values

IV. Plan Design Factor - See Table B

Equals Premium Cost divided by standard benefit plan premium.

Base Plan Medical = US, 80% coinsurance, \$0 deductible, \$2k out-of-pocket, \$5m maximum.

Base Plan Rx = Unlimited maximum, no copays or coinsurance

V. Relative Geographical Cost - See Table C

U.S. In-network: .90 for medical, 1.00 for Rx U.S. Out-of-network: 1.25 for medical, 1.00 for Rx

Overseas: .35 times area factor for medical (weighted average by enrollment), .65 for Rx

VI. Office Visit Copay Factor

Expected number of office visits times cost of an office visit times coinsurance

minus expected number of office visits times cost of an office visit less the office visit copay

all divided by the base rate

VII. Hospital Out-of-Network Copay Factor

The factor is .97 if there is a hospital out-of-network copay

VIII. Medical Evacuation Factor - Table D

From the table shown below; interim values interpolated

IX. Integrated Deductible Factor (Medical and Rx)

For high deductibles, the Rx cost is reduced by 35%.

For deductibles below \$250, it is reduced by 35% times deductible/250

X. Trend Factors

Monthly Factor = 1 + annual factor/12 ** months from manual date to effective date

| Benefit | Annual Factor |
|------------|---------------|
| Medical Rx | 10.3% |
| Dental | 6.0% |
| Vision | 4.0% |
| | |

XI. Anti-Selection Factor (interpolated for interim values)

| Plan Design Factor | Factor |
|--------------------|--------|
| 0.4 | -0.12 |
| 0.5 | -0.09 |
| 0.6 | -0.06 |
| 0.7 | -0.03 |
| 0.8 | 0.00 |
| 0.9 | 0.03 |

XII. Maximum Benefit Factor (interpolated for interim values)

| Maximum Benefit | Factor |
|-----------------|--------|
| 0 | 0.00 |
| 1.100.000 | 0.03 |

6,000,000 0.05 999,999,999 0.07

XIII. Group Size Factor (interpolated for interim values)

| Group Size Factor | Factor |
|-------------------|--------|
| 1 | 0.425 |
| 2 | 0.350 |
| 3 | 0.275 |
| 4 | 0.200 |
| 5 | 0.125 |
| 6 | 0.050 |
| 7+ | 0.000 |

XIV. Age Gender Factors (weighted average by enrollment)

| Age | Male | Female | Dep. Child |
|-------------|-------|--------|------------|
| 0-24 | 0.33 | 0.75 | 0.367 |
| 25-29 | 0.41 | 0.98 | 0.367 |
| 30-34 | 0.52 | 1.14 | 0.367 |
| 35-39 | 0.67 | 1.14 | 0.367 |
| 40-44 | 0.83 | 1.17 | 0.367 |
| 45-49 | 1.06 | 1.38 | 0.367 |
| 50-54 | 1.45 | 1.67 | 0.367 |
| 55-59 | 1.89 | 1.97 | 0.367 |
| 60-64 | 2.56 | 2.34 | 0.367 |
| 65-69 | 3.45 | 2.78 | 0.367 |
| 70-74 | 4.91 | 3.96 | 0.367 |
| 75-79 | 6.12 | 4.94 | 0.367 |
| 80-84 | 7.31 | 5.9 | 0.367 |
| 85-89 | 8.87 | 7.16 | 0.367 |
| 90-94 | 11.32 | 9.13 | 0.367 |
| 95 or above | 12.4 | 10.01 | 0.367 |
| | | | |

XV. Retention

| Group Size | Retention Before Commission |
|------------|-----------------------------|
| 1 | 0.385 |
| 2-399 | 0.365 |
| 400+ | 0.245 |

XVI. Dental and Vision

Only one dental plan and one vision plan is to be sold. The rates do not vary by age, area, group size, retention, commission, etc.

The Premium rates for an Employee, Spouse and Child are as follows:

| Relation | Dental | Vision |
|----------|---------|---------|
| EE | \$43.00 | \$14.00 |
| Spouse | \$49.00 | \$14.00 |
| Child | \$12.90 | \$4.20 |

XVII. Tier Factors

Since rates are calculated for Employee (or Participant), Spouse and Child, the tier rates are derived.

The number of expected spouses per employee and children per employee at each tier is as follows:

| | | #Sp in Tier | #Chrn in Tier |
|------------|----------------|-------------|---------------|
| Two Tier | Comp Dep | 0.9 | 1.8 |
| Three Tier | One Dep | 0.9 | 0.1 |
| Three Tier | 2+ Deps | 0.9 | 2.5 |
| Four Tier | Spouse | 1 | 0 |
| Four Tier | Child/Children | 0 | 2 |
| Four Tier | Family | 1 | 3.1 |

XVIII. Experience Rating (See Table E)

For larger groups, an experience rate is used for Medical and Rx when actual credible claims is obtainable.

A blend of the manual rate and an experience rate will be used weighted by a credibility factor (CF) (See Table E).

Actual claims is adjusted from the midpoint of the experience period to the midpoint of the rating period.

If claims are on a paid basis (rather than an incurred basis), lagged actual claims may be used.

If sufficient data is available, incurred claims will be calculated using a claims triangle reserve method.

Actual claims may also be adjusted if benefits or network availability will be changed.

The basic formula is as follows:

Final Rate = Experience Rate times CF plus Manual Rate times (1-CF)

Sample Rate Calculation Policy Effective 1/1/2015

| 1 Medical Benefit | US-IN | US-OUT | Oversea | Rx | | | | | |
|--|------------------|----------------|----------------|-------------------|---------------|--------------|------|--------------|----------|
| 2 Location | US | US | Oversea | All | | | | | |
| 3 Coinsurance | 80% | 60% | 90% | 100% | | | | | |
| 4 Deductible | \$0 | \$1,000 | \$50 | \$0 | | | | | |
| 5 Out-of-Pocket | \$2,000 | \$2,000 | \$2,000 | No Copays | | | | | |
| 6 Maximum 7 Rx-Integrated-Deduc? | \$5m N | \$5m N | \$5m N | Unlimited | | | | | |
| 8 OfficeVisitCopay, i.e. 10 | \$30 | N N | N N | | | | | | |
| 9 Hospital Out-of-Network | NA | N | NA | | | | | | |
| 10 AD&D | N | N N | N | | | | | | |
| 11 Medical Evacuation | \$100,000 | \$100,000 | \$100,000 | | | | | | |
| 12 Medical Base Rate | \$337.00 | \$337.00 | \$337.00 | | | | | | |
| 13 Usage Percent | 0.25 | 0.05 | 0.70 | | | | | | |
| 14 Plan Design Factor | 1.000 | 0.826 | 1.006 | | | | | | |
| 15 Relative Geographical Cost | 0.900 | 1.250 | 0.350 | | | | | | |
| 16 Office Visit Copay | 0.997 1.000 | 1.000 1.000 | 1.000 1.000 | | | | | | |
| 17 Hospital Out-of-Network 18 Medical Evaculation Adj | 1.000 | 1.000 | 1.000 | | | | | | |
| 19 Untrended Medical Plan | \$75.60 | \$17.40 | \$83.06 | \$176.06 | | | | | |
| 20 Rx Base Rate | \$100.40 | \$100.40 | \$100.40 | | | | | | |
| 21 Usage Percent | 0.25 | 0.05 | 0.70 | | | | | | |
| 22 Plan Design Factor | 1.000 | 1.000 | 1.000 | | | | | | |
| 23 Coinsurance | 100% | 100% | 100% | | | | | | |
| 24 Integrated Deductible Factor | 1.000 | 1.000 | 1.000 | | | | | | |
| • | 1.000 | 1.000 | 0.650 | | | | | | |
| 25 Relative Geographical Cost 26 Untrended Rx Plan Cost | 25.10 | 5.02 | 45.68 | \$75.80 | | | | | |
| | 25.10 | 5.02 | 45.00 | \$251.86 | | | | | |
| 27 Untrended Medical & Rx (19+26) | 1.000 | 4.005 | 1 000 | | | | | | |
| 28 Trend: Medical/Rx; Den 29 Anti-Selection Factor | 1.009 0.030 | 1.005 | 1.003 | | | | | | |
| 30 Maximum Benefit Factor | | | | | | | | | |
| | 0.030 | | | | | | | | |
| 31 Group Size Factor | 0.000 | | | #200 ac | | | | | |
| 32 Combined Factors (28*(33 AD&D | 1.069 | 0.000 | NA | \$269.26 | | | | | |
| | 0.000 | 0.000 | | | | | | | |
| 34 Age Factors (Partic, Sp, Children) | 1.000 | 1.000 | 0.367 | | | | | | |
| 35 Med&Rx Before Retention | 269.26 | 269.26 | 98.82 | | | | | | |
| 36 Med,Rx,ADD Before Retention | 269.26 | 269.26 | 98.82 | | | | | | |
| 37 Retention(R) & Commission(C) | 0.245 | 0.050 | 407.77 | | | | | | |
| 38 Rates After Retention (P | 375.41 269.26 | 375.41 | 137.77 | | | | | | |
| 39 Med,Rx Per Employee | 209.20 | | | | | , | AA | BB | |
| 2 Tier | 411-16- | 50 D. 400 | DENTAL | MOION | TOTAL | #Sp in Tier | #C | Chrn in tier | |
| 40 Particle and (00 an) | #Units | ED-Rx-AD& | DENTAL | VISION | | | | | |
| 40 Participant (38ee) | 438 | \$375.41 | \$43.22 | \$14.05 | | , | | 4.0 | |
| 41 Participant & Family | 0 | \$961.27 | \$110.87 | \$34.27 | £400 £44 | (| 0.9 | 1.8 | |
| 42 Total Mo Prem-2 Tier | 438 | \$164,430 | \$18,930 | \$6,154 | \$189,514 | | | | |
| 3 Tier | | | | | | | | | |
| 43 Participant (38ee) | 438 | \$375.41 | \$43.22 | \$14.05 | | | | | |
| 44 Participant Plus One | 0 | \$727.06 | \$88.83 | \$27.11 | | |).9 | 0.1 | |
| 45 Participant Plus Family | 0 | \$1,057.70 | \$119.95 | \$37.22 | | C |).9 | 2.5 | |
| 46 Total Mo Prem-3 Tier | 438 | \$164,430 | \$18,930 | \$6,154 | \$189,514 | | | | |
| | EXPERIENCE I | RATE | | | | | | | |
| E1 Experience Period Begins: | | 11/1/12 | E14 Experie | nce PEPM (E6*(1 | +E10)*E12/E | 13) | | | \$252.73 |
| E2 Experience Period Ends: | | 10/31/14 | E15 Experie | nce "Using Lagge | ed" (E7*(1+E1 | 0)*E12/E13) | | | \$256.29 |
| E3 Number of Months Experience: | | 24 | | Expected PEPM | | | | | 269.26 |
| E4 Enrolled Months | | 9,672 | E17 Credibil | ity Factor (CF) | | | | | 90.00% |
| E5 Actual Claims | | 2,075,887 | | Claims Cost = E | xperience*CF | + Manual*(1- | ·CF) | | \$254.38 |
| E6 Actual PEPM | | \$214.63 | E19 Retention | | | • | - | | 0.245 |
| E7 Lagged PEPM | | \$217.65 | E20 Commis | ssion | | | | | 0.050 |
| E8 Months Trended (mdpt to mdpt) | | 20 | | emium Charged (| (PEPM) | | | | \$354.66 |
| E9 Annual Trend Factor | | 0.103 | | ILR - Medical Los | , | | | | 71.7% |
| E10 Trend from midpt to midpt | | 17.75% | | | | | | | |
| E11 Lagged is this percent over Actual | | 1.4% | | | | | | | |
| E12 Plan or other differential | | 1.000 | | | | | | | |
| E13 Adjustment to incur claims | | 1.000 | | | | | | | |
| | | | | | | | | | |

TABLE A - Claims Premium Table

| Claims | Premium |
|-------------|----------|
| \$0 | \$337.00 |
| \$50 | \$332.46 |
| \$100 | \$328.95 |
| \$150 | \$325.47 |
| \$200 | \$322.44 |
| \$250 | \$319.46 |
| \$300 | \$316.47 |
| \$350 | \$313.72 |
| \$400 | \$311.09 |
| \$450 | \$308.45 |
| \$500 | \$305.97 |
| \$750 | \$294.74 |
| \$1,000 | \$285.07 |
| \$1,500 | \$269.16 |
| \$2,000 | \$256.11 |
| \$2,500 | \$245.02 |
| \$3,000 | \$235.43 |
| \$4,000 | \$219.02 |
| \$5,000 | \$205.82 |
| \$7,500 | \$180.17 |
| \$10,000 | \$161.01 |
| \$15,000 | \$132.87 |
| \$20,000 | \$113.80 |
| \$25,000 | \$99.80 |
| \$30,000 | \$88.89 |
| \$35,000 | \$80.28 |
| \$40,000 | \$73.31 |
| \$45,000 | \$67.35 |
| \$50,000 | \$62.45 |
| \$60,000 | \$54.17 |
| \$70,000 | \$47.52 |
| \$80,000 | \$42.23 |
| \$90,000 | \$37.74 |
| \$100,000 | \$34.17 |
| \$125,000 | \$27.22 |
| \$150,000 | \$22.23 |
| \$175,000 | \$18.50 |
| \$200,000 | \$15.63 |
| \$225,000 | \$13.41 |
| \$250,000 | \$11.53 |
| \$300,000 | \$8.67 |
| \$400,000 | \$5.20 |
| \$500,000 | \$3.30 |
| \$1,000,000 | \$0.37 |
| Unlimited | \$0.00 |
| | |

base rates are for a policy year starting 12/1/2014

TABLE B - Sample of Plans with Benefit Design Factors

| | | | | OOP | Annual | |
|-----------|---------|-------|----------|----------|-------------|-----------------|
| Med Plan# | Loc | Coins | Ded | (addDed) | Limit | Ben Design Fctr |
| 0 | | | | | | |
| 1 | US | 80% | \$0 | \$2,000 | \$5,000,000 | 1.000 |
| 2 | US | 60% | \$1,000 | \$2,000 | \$5,000,000 | 0.828 |
| 3 | Oversea | 100% | \$0 | \$2,000 | \$5,000,000 | 1.117 |
| 4 | US | 80% | \$500 | \$3,000 | \$5,000,000 | 0.900 |
| 5 | US | 60% | \$1,000 | \$3,000 | \$5,000,000 | 0.797 |
| 6 | Oversea | 100% | \$250 | \$3,000 | \$5,000,000 | 1.017 |
| 7 | US | 80% | \$1,000 | \$4,000 | \$5,000,000 | 0.831 |
| 8 | US | 60% | \$2,000 | \$4,000 | \$5,000,000 | 0.709 |
| 9 | Oversea | 100% | \$500 | \$4,000 | \$5,000,000 | 0.948 |
| 10 | US | 80% | \$2,000 | \$8,000 | \$5,000,000 | 0.728 |
| 11 | US | 60% | \$4,000 | \$8,000 | \$5,000,000 | 0.573 |
| 12 | Oversea | 100% | \$1,000 | \$8,000 | \$5,000,000 | 0.851 |
| 13 | US | 80% | \$5,000 | \$10,000 | \$5,000,000 | 0.585 |
| 14 | US | 60% | \$10,000 | \$10,000 | \$5,000,000 | 0.427 |
| 15 | Oversea | 80% | \$2,500 | \$10,000 | \$5,000,000 | 0.569 |

| | | | | | Annual | Benfit Design Factors - |
|----------|-----|-------|-----|----------|-----------|-------------------------|
| Rx Plan# | Loc | Coins | Ded | OOP | Limit | Maximum Payment |
| 0 | | | | | | |
| 1 | All | 100% | \$0 | No Limit | \$500 | 0.1985 |
| 2 | All | 100% | \$0 | No Limit | \$1,000 | 0.3178 |
| 3 | All | 100% | \$0 | No Limit | \$1,200 | 0.3560 |
| 4 | All | 100% | \$0 | No Limit | \$5,000 | 0.7032 |
| 5 | All | 100% | \$0 | No Limit | \$25,000 | 0.9213 |
| 6 | All | 100% | \$6 | No Limit | Unlimited | 1.0000 |

TABLE C - Area Factors (weighted average by enrollment)

| IADEL C - Alea I | actors | (weighted average by emon | inent) | | |
|---------------------|--------|---------------------------|--------|---------------------|--------|
| Area | Factor | Area | Factor | Area | Factor |
| AFGHANISTAN | 0.92 | FIJI | 0.92 | NEPAL | 0.92 |
| AFRICA | 0.81 | FINLAND | 1.13 | NETHERLAND ANTILLES | 1.08 |
| AFRICAN | 0.81 | FR. PACIFIC ISLANDS | 0.92 | NETHERLANDS | 0.96 |
| ALBANIA | 1.13 | FRANCE | 1.13 | NEW ZEALAND | 0.92 |
| ALGERIA | 0.81 | | | NICARAGUA | 1.08 |
| | | FRENCH COMM IN AFRICA | | | |
| ANDORRA FRENCH | 1.13 | FRENCH GUIANA | 1.08 | NIGER | 0.81 |
| ANDORRA SPANISH | 1.13 | GABON | 0.81 | NIGERIA | 0.81 |
| ANGOLA | 0.81 | GAMBIA | 0.81 | NORTH AMERICA | 1.55 |
| ANTIGUA | 1.08 | GERMANY | 1.13 | NORWAY | 1.13 |
| ARGENTINA | 1.08 | GHANA | 0.81 | OMAN | 1.01 |
| ARMENIA | 1.13 | GIBRALTAR | 1.13 | OTHER CHINA | 1.16 |
| ARUBA | 1.08 | GREECE | 1.13 | PAKISTAN | 0.92 |
| AUSTRALIA | 0.84 | GREENLAND | 1.13 | PANAMA | 1.08 |
| | | | | | |
| AUSTRIA | 1.13 | GRENADA | 1.08 | PAPUA NEW GUINEA | 0.92 |
| AZERBAIJAN | 1.13 | GUADALOUPE | 1.08 | PARUGUAY | 1.08 |
| AZORES | 1.13 | GUAM | 0.92 | PERU | 1.08 |
| BAHAMAS | 1.08 | GUATEMALA | 1.08 | PHILIPPINES | 0.79 |
| BAHRAIN | 1.01 | GUINEA BISSAU | 0.81 | POLAND | 1.13 |
| BANGLADESH | 0.92 | GUINEA REPUBLIC | 0.81 | PORTUGAL | 1.13 |
| BARBADOS | 1.08 | GUYANA | 1.08 | PUERTO RICO | 1.08 |
| BEIJING | 1.55 | HAITI | 1.08 | QATAR | 1.01 |
| BELARUS | 1.13 | HONDURAS | 1.08 | REUNION ISLANDS | 0.81 |
| | | | | | |
| BELGIUM | 0.96 | HONG KONG | 1.35 | ROMANIA | 1.13 |
| BELIZE | 1.08 | HUNGARY | 1.13 | RWANDA | 0.81 |
| BENIN | 0.81 | ICELAND | 1.13 | SAO TOME E PRINCIPE | 0.81 |
| BERMUDA | 1.08 | INDIA | 0.92 | SAUDI | 1.01 |
| BHUTAN | 0.92 | INDONESIA | 0.73 | SAUDI ARABIA | 1.01 |
| BOLIVIA | 1.08 | IRAN | 1.01 | SENEGAL | 0.81 |
| BOSNIA HERZEGOVENA | 1.13 | IRAQ | 1.01 | SEYCHELLES | 0.81 |
| BOTSWANA | 0.81 | IRELAND | 0.96 | SHANGHAI | 1.55 |
| BRAZIL | 1.22 | ISRAEL | 1.55 | SIERRA LEONE | 0.81 |
| | | | | | |
| BRUNEI | 0.92 | ITALY | 1.13 | SINGAPORE | 1.18 |
| BULGARIA | 1.13 | IVORY COAST | 0.81 | SLOVAKIA | 1.13 |
| BURKINO FASCO | 0.81 | JAMAICA | 1.08 | SLOVENIA | 1.13 |
| BURMA | 0.92 | JAPAN | 0.92 | SOLOMON ISLANDS | 0.92 |
| BURUNDI | 0.81 | JERSEY | 1.13 | SOMALI REPUBLIC | 0.81 |
| C&S AMER 1 | 1.08 | JORDAN | 1.01 | SOUTH AFRICA | 0.81 |
| C&S AMER 2 | 1.08 | KAZAKHSTAN | 1.13 | SOUTH AMERICA | 1.08 |
| CAMBODIA | 0.92 | KENYA | 0.81 | SPAIN | 1.13 |
| | | | | | |
| CAMEROON | 0.81 | KIRIBATI | 0.92 | SRI LANKA | 0.92 |
| CANADA | 1.09 | KOREA | 0.92 | ST LUCIA | 1.08 |
| CANARY ISLANDS | 0.81 | KOREA SOUTH | 0.92 | SUDAN | 0.81 |
| CANARY ISLES | 1.13 | KUWAIT | 1.01 | SWAZILAND | 0.81 |
| CAPE VERDE | 0.81 | LAOS | 0.92 | SWEDEN | 1.13 |
| CAYMAN ISLANDS | 1.08 | LATVIA | 1.13 | SWITZERLAND | 1.55 |
| CENTRAL AFRICAN REP | 0.81 | LEBANON | 1.01 | SYRIA | 1.01 |
| CHAD | 0.81 | LEICHTENSTEIN | 1.13 | TAIWAN | 0.92 |
| CHILE | 1.08 | LESOTHO | 0.81 | TANZANIA | 0.81 |
| | | | | | |
| CIS | 1.13 | | 0.81 | THAILAND | 0.8 |
| COLOMBIA | 1.08 | LIBYA | 0.81 | TOGO REPUBLIC | 0.81 |
| COMORO ISLANDS | 0.81 | LITHUANIA | 1.13 | TONGA | 0.92 |
| CONGO | 0.81 | LUXEMBOURG | 1.13 | TRINIDAD & TOBAGO | 1.08 |
| COSTA RICA | 1.08 | MACAU | 0.92 | TUNISIA | 0.81 |
| CROATIA | 1.13 | MADAGASCAR | 0.81 | TURKEY | 1.01 |
| CUBA | 1.55 | | 1.13 | IUKKO & CAICUO | 1.08 |
| CYPRUS | 1.13 | | 0.81 | UAE | 1.01 |
| | | | | | |
| CZECH REPUBLIC | 1.13 | | 0.92 | UGANDA | 0.81 |
| DENMARK | 1.28 | | 0.92 | UKRAINE | 1.13 |
| DJIBOUTI | 0.81 | MALI REPUBLIC | 0.81 | UNITED KINGDOM | 1.18 |
| DOMINICA ISLE | 1.08 | MALTA | 1.13 | UNKNOWN | 1.1 |
| DOMINICAN REPUBLIC | 1.08 | MARSHALL ISLANDS | 0.92 | URUGUAY | 1.08 |
| EAST GERMANY | 1.13 | MARTINIQUE | 1.08 | US | |
| ECUADOR | 1.08 | MAURITANIA | 0.81 | UZBEKISTAN | 1.13 |
| EGYPT | 0.81 | MAURITIUS | 0.81 | VANUATA | 0.92 |
| EL SALVADOR | | MEXICO | 1.27 | VENEZUELA | 1.08 |
| | 1.08 | | | | |
| EQUATORIAL GUINEA | 0.81 | MIDDLE EAST | 1.01 | VIETNAM | 0.92 |
| ESTONIA | 1.13 | | 1.13 | VIRGIN ISLANDS (Br) | 1.08 |
| ETHIOPIA | 0.81 | MONACO | 1.13 | WESTERN SOMOA | 0.92 |
| EUROPE | 1.13 | MONGOLIA | 0.92 | YEMEN | 1.01 |
| EUROPEAN | 1.13 | | 0.81 | YEMEN, REP | 1.01 |
| FALKLAND ISLANDS | 1.08 | | 0.81 | YUGOSLAVIA | 1.13 |
| FAR EAST 1 | 0.92 | | 1.01 | ZAIRE | 0.81 |
| | | | | | |
| FAR EAST 2 | 0.92 | | 1.55 | ZAMBIA | 0.81 |
| FAROE ISLANDS | 1.13 | NAMIBIA | 0.81 | ZIMBABWE | 0.81 |

1

TABLE C cont. - Area Factors (weighted average by enrollment) U.S. Area Factors

| 0 1: 1: 7: | 0 | |
|-------------|--------------|--------------------|
| 3-digit Zip | <u>State</u> | <u>AF</u> 0.775 |
| 002 | NH NY | |
| 004 | NY | 1.143 1.124 |
| 005 | PR | 0.666 |
| 006 | | 0.666 |
| 007 | PR | |
| 009 | PR | 0.666 |
| 010 | MA | 0.843 |
| 011 | MA | 0.843 |
| 012 | MA | 0.886 |
| 013 | MA | 0.837 |
| 014 | MA | 0.872 |
| 015 | MA | 0.872 |
| 016 | MA | 0.872 |
| 017 | MA | 0.903 |
| 018 | MA | 0.903 |
| 019 | MA | 0.939 |
| 020 | MA | 0.939 |
| 021 | MA | 0.939 |
| 022 | MA | 0.939 |
| 023 | MA | 0.872 |
| 024 | MA | 0.872 |
| 025 | MA | 0.876 |
| 026 | MA | 0.891 |
| 027 | MA | 0.872 |
| 028 | RI | 0.881 |
| 029 | RI | 0.882 |
| 030 | NH | 0.781 |
| 031 | NH | 0.778 |
| 032 | NH | 0.739 |
| 033 | NH | 0.732 |
| 034 | NH | 0.740 |
| 035 | NH | 0.732 |
| 036 | NH | 0.732 |
| 037 | NH | 0.732 |
| 038 | NH | 0.775 |
| 039 | ME | 0.755 |
| 040 | ME | 0.767 |
| 041 | ME | 0.780 |
| 042 | ME | 0.797 |
| 043 | ME | 0.755 |
| 044 | ME | 0.775 |
| 045 | ME | 0.755 |
| 046 | ME | 0.755 |
| 047 | ME | 0.756 |
| 048 | ME | 0.755 |
| 049 | ME | 0.757 |
| 050 | VT | 0.682 |
| 051 | VT | 0.682 |
| 052 | VT | 0.682 |
| 053 | VT | 0.682 |
| 054 | VT | 0.721 |
| 055 | MA | 0.903 |
| 056 | VT | 0.682 |
| 057 | VT | 0.682 |
| 058 | VT | 0.682 |
| 059 | VT | 0.682 |
| 060 | CT | 0.831 |
| 061 | CT | 0.833 |
| 062 | CT | 0.814 |
| 063 | СТ | 0.805 |
| 064 | CT | 0.909 |
| 065 | CT | 0.919 |
| 066 | CT | 0.919 |
| 067 | CT | 0.857 |
| 001 | 01 | 0.007 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| ILC Area F | t | actors (we |
|-------------|----|------------|
| U.S. Area F | | 0.040 |
| 068 | CT | 0.919 |
| 069 | CT | 0.919 |
| 070 | NJ | 1.064 |
| 071 | NJ | 1.067 |
| 072 | NJ | 1.067 |
| 073 | NJ | 1.073 |
| 074 | NJ | 1.024 |
| 075 | NJ | 1.021 |
| 076 | NJ | 1.053 |
| 077 | NJ | 1.078 |
| 078 | NJ | 1.004 |
| 079 | NJ | 1.033 |
| 080 | NJ | 1.138 |
| 081 | NJ | 1.143 |
| 082 | NJ | 0.982 |
| 083 | NJ | 1.010 |
| 084 | NJ | 0.982 |
| | | |
| 085 | NJ | 1.043 |
| 086 | NJ | 1.046 |
| 087 | NJ | 1.078 |
| 088 | NJ | 0.989 |
| 089 | NJ | 0.988 |
| 090 | NY | 0.963 |
| 091 | NY | 0.963 |
| 092 | NY | 0.963 |
| 093 | NY | 0.963 |
| 094 | NY | 0.963 |
| 095 | NY | 0.963 |
| 096 | NY | 0.963 |
| | NY | |
| 097 | | 0.963 |
| 098 | NY | 0.963 |
| 100 | NY | 1.246 |
| 101 | NY | 1.246 |
| 102 | NY | 1.246 |
| 103 | NY | 1.188 |
| 104 | NY | 1.188 |
| 105 | NY | 1.143 |
| 106 | NY | 1.143 |
| 107 | NY | 1.143 |
| 108 | NY | 1.143 |
| 109 | NY | 1.093 |
| 110 | NY | 1.229 |
| 111 | NY | 1.188 |
| 112 | NY | 1.188 |
| | | |
| 113 | NY | 1.188 |
| 114 | NY | 1.188 |
| 115 | NY | 1.169 |
| 116 | NY | 1.143 |
| 117 | NY | 1.124 |
| 118 | NY | 1.124 |
| 119 | NY | 1.124 |
| 120 | NY | 0.746 |
| 121 | NY | 0.747 |
| 122 | NY | 0.747 |
| 123 | NY | 0.747 |
| 124 | NY | 0.790 |
| 125 | NY | 0.862 |
| | | |
| 126 | NY | 0.876 |
| 127 | NY | 0.811 |
| 128 | NY | 0.748 |
| 129 | NY | 0.741 |
| 130 | NY | 0.713 |
| 131 | NY | 0.712 |
| 132 | NY | 0.714 |
| 133 | NY | 0.721 |
| 134 | NY | 0.723 |
| 135 | NY | 0.728 |
| | | |

TABLE C cont. - Area Factors (weighted average by enrollment)

| IABLE C | | actors (weight |
|-----------|---------|----------------|
| U.S. Area | Factors | |
| 136 | NY | 0.705 |
| 137 | NY | 0.721 |
| 138 | NY | 0.715 |
| 139 | NY | 0.726 |
| 140 | NY | 0.691 |
| | | |
| 141 | NY | 0.692 |
| 142 | NY | 0.691 |
| 143 | NY | 0.691 |
| 144 | NY | 0.691 |
| 145 | NY | 0.693 |
| 146 | NY | 0.691 |
| 147 | NY | 0.691 |
| 148 | NY | 0.710 |
| 149 | NY | 0.738 |
| 150 | PA | 0.971 |
| | | |
| 151 | PA | 1.007 |
| 152 | PA | 1.007 |
| 153 | PA | 0.916 |
| 154 | PA | 0.939 |
| 155 | PA | 0.835 |
| 156 | PA | 0.901 |
| 157 | PA | 0.810 |
| 158 | PA | 0.803 |
| 159 | PA | 0.856 |
| | PA | 0.905 |
| 160 | | |
| 161 | PA | 0.835 |
| 162 | PA | 0.803 |
| 163 | PA | 0.803 |
| 164 | PA | 0.848 |
| 165 | PA | 0.852 |
| 166 | PA | 0.848 |
| 167 | PA | 0.803 |
| 168 | PA | 0.791 |
| 169 | PA | 0.803 |
| 170 | PA | 0.837 |
| | | |
| 171 | PA . | 0.848 |
| 172 | PA | 0.813 |
| 173 | PA | 0.777 |
| 174 | PA | 0.768 |
| 175 | PA | 0.776 |
| 176 | PA | 0.776 |
| 177 | PA | 0.810 |
| 178 | PA | 0.814 |
| 179 | PA | 0.804 |
| 180 | PA | 0.907 |
| 181 | PA | 0.889 |
| | | |
| 182 | PA | 0.877 |
| 183 | PA | 0.820 |
| 184 | PA | 0.837 |
| 185 | PA | 0.854 |
| 186 | PA | 0.852 |
| 187 | PA | 0.854 |
| 188 | PA | 0.803 |
| 189 | PA | 1.210 |
| 190 | PA | 1.246 |
| | PA | |
| 191 | | 1.273 |
| 192 | PA | 1.273 |
| 193 | PA | 1.210 |
| 194 | PA | 1.210 |
| 195 | PA | 0.801 |
| 196 | PA | 0.774 |
| 197 | DE | 0.851 |
| 198 | DE | 0.851 |
| 199 | DE | 0.879 |
| 200 | DC | 0.993 |
| | | |
| 201 | VA | 0.890 |
| 202 | DC | 0.993 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| IABLE C | ont Area | ractors (weighted |
|-------------|----------|-------------------|
| U.S. Area I | Factors | |
| 203 | DC | 0.993 |
| 204 | DC | 0.993 |
| 205 | DC | 0.993 |
| | MD | |
| 206 | | 0.828 |
| 207 | MD | 0.858 |
| 208 | MD | 0.890 |
| 209 | MD | 0.890 |
| 210 | MD | 0.857 |
| 211 | MD | 0.857 |
| 212 | MD | 0.888 |
| 214 | MD | 0.857 |
| | | |
| 215 | MD | 0.755 |
| 216 | MD | 0.737 |
| 217 | MD | 0.789 |
| 218 | MD | 0.715 |
| 219 | MD | 0.801 |
| 220 | VA | 0.890 |
| | | |
| 221 | VA | 0.890 |
| 222 | VA | 0.957 |
| 223 | VA | 0.957 |
| 224 | VA | 0.826 |
| 225 | VA | 0.810 |
| 226 | VA | 0.764 |
| 227 | VA | 0.795 |
| | | |
| 228 | VA | 0.745 |
| 229 | VA | 0.752 |
| 230 | VA | 0.814 |
| 231 | VA | 0.805 |
| 232 | VA | 0.866 |
| 233 | VA | 0.737 |
| 234 | VA | 0.764 |
| | | |
| 235 | VA | 0.764 |
| 236 | VA | 0.764 |
| 237 | VA | 0.764 |
| 238 | VA | 0.811 |
| 239 | VA | 0.745 |
| 240 | VA | 0.759 |
| 241 | VA | 0.751 |
| 242 | VA | 0.771 |
| | VA | 0.714 |
| 243 | | |
| 244 | VA | 0.710 |
| 245 | VA | 0.737 |
| 246 | VA | 0.745 |
| 247 | WV | 0.768 |
| 248 | WV | 0.768 |
| 249 | WV | 0.768 |
| 250 | WV | 0.817 |
| | | |
| 251 | WV | 0.816 |
| 252 | WV | 0.800 |
| 253 | WV | 0.830 |
| 254 | WV | 0.805 |
| 255 | WV | 0.797 |
| 256 | WV | 0.769 |
| 257 | WV | 0.816 |
| | WV | 0.768 |
| 258 | | |
| 259 | WV | 0.768 |
| 260 | WV | 0.828 |
| 261 | WV | 0.769 |
| 262 | WV | 0.768 |
| 263 | WV | 0.768 |
| 264 | WV | 0.768 |
| 265 | WV | 0.732 |
| | | |
| 266 | WV | 0.768 |
| 267 | WV | 0.769 |
| 268 | WV | 0.768 |
| 270 | NC | 0.719 |
| 271 | NC | 0.717 |
| | | |

TABLE C cont. - Area Factors (weighted average by enrollment)

| HABEL C | | actors (v |
|-----------|----|-----------|
| U.S. Area | | |
| 272 | NC | 0.720 |
| 273 | NC | 0.721 |
| 274 | NC | 0.717 |
| 275 | NC | 0.783 |
| 276 | NC | 0.759 |
| 277 | NC | 0.795 |
| 278 | NC | 0.733 |
| 279 | NC | 0.716 |
| 280 | NC | 0.742 |
| 281 | NC | 0.737 |
| 282 | NC | 0.749 |
| 283 | NC | 0.764 |
| 284 | NC | 0.757 |
| 285 | NC | 0.735 |
| 286 | NC | 0.746 |
| 287 | NC | 0.724 |
| 288 | NC | 0.739 |
| 289 | NC | 0.718 |
| 290 | sc | 0.795 |
| 291 | sc | 0.799 |
| 292 | SC | 0.796 |
| 293 | SC | 0.797 |
| 294 | SC | 0.842 |
| 295 | SC | 0.808 |
| 296 | SC | 0.797 |
| | SC | |
| 297 | | 0.789 |
| 298 | SC | 0.808 |
| 299 | SC | 0.794 |
| 300 | GA | 0.864 |
| 301 | GA | 0.859 |
| 302 | GA | 0.829 |
| 303 | GA | 0.864 |
| 304 | GA | 0.808 |
| 305 | GA | 0.810 |
| 306 | GA | 0.854 |
| 307 | GA | 0.842 |
| 308 | GA | 0.848 |
| 309 | GA | 0.862 |
| 310 | GA | 0.815 |
| 311 | GA | 0.864 |
| 312 | GA | 0.887 |
| 313 | GA | 0.822 |
| 314 | GA | 0.871 |
| 315 | GA | 0.786 |
| 316 | GA | 0.786 |
| 317 | GA | 0.798 |
| 318 | GA | 0.818 |
| 319 | GA | 0.833 |
| 320 | FL | 0.960 |
| 321 | FL | 0.937 |
| 322 | FL | 0.980 |
| 323 | FL | 0.879 |
| 324 | FL | 0.901 |
| 325 | FL | 0.936 |
| 326 | FL | 0.927 |
| 327 | FL | 0.964 |
| 328 | FL | 0.961 |
| 329 | FL | 0.924 |
| 330 | FL | 1.298 |
| 331 | FL | 1.350 |
| 332 | FL | 1.350 |
| 333 | FL | 1.269 |
| 334 | FL | 1.174 |
| | FL | 1.174 |
| 335 | | |
| 336 | FL | 1.007 |
| 337 | FL | 1.007 |
| 338 | FL | 0.955 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| | ont Area | ractors (|
|-------------|----------|-----------|
| U.S. Area F | actors | |
| 339 | FL | 0.982 |
| 341 | FL | 1.094 |
| 342 | FL | 0.959 |
| 344 | FL | 0.918 |
| 346 | FL | 0.975 |
| 347 | FL | 0.960 |
| 349 | FL | 1.061 |
| 350 | AL | 0.948 |
| 351 | AL | 0.987 |
| 352 | AL | 1.016 |
| 354 | AL | 0.940 |
| 355 | AL | 0.865 |
| 356 | AL | 0.885 |
| 357 | AL | 0.859 |
| 358 | AL | 0.852 |
| 359 | AL | 0.898 |
| 360 | AL | 0.867 |
| 361 | AL | 0.870 |
| 362 | AL | 0.940 |
| 363 | AL | 0.859 |
| 364 | AL | 0.865 |
| 365 | AL | 0.846 |
| 366 | | |
| | AL | 0.842 |
| 367 | AL | 0.865 |
| 368 | AL | 0.816 |
| 369 | AL | 0.865 |
| 370 | TN | 0.827 |
| 371 | TN | 0.850 |
| 372 | TN | 0.888 |
| 373 | TN | 0.802 |
| 374 | TN | 0.895 |
| 375 | TN | 0.884 |
| 376 | TN | 0.807 |
| 377 | TN | 0.854 |
| 378 | TN | 0.808 |
| 379 | TN | 0.863 |
| 380 | TN | 0.842 |
| 381 | TN | 0.884 |
| 382 | TN | 0.783 |
| 383 | TN | 0.788 |
| 384 | TN | 0.783 |
| 385 | TN | 0.783 |
| 386 | MS | 0.784 |
| 387 | MS | 0.728 |
| 388 | MS | 0.728 |
| 389 | MS | 0.728 |
| 390 | MS | 0.760 |
| 391 | MS | 0.778 |
| 392 | MS | 0.821 |
| 393 | MS | 0.728 |
| 394 | MS | 0.754 |
| 395 | MS | 0.911 |
| 396 | MS | 0.728 |
| 397 | MS | 0.728 |
| 399 | GA | 0.864 |
| 400 | KY | 0.798 |
| 401 | KY | 0.821 |
| 402 | KY | 0.865 |
| 403 | KY | 0.806 |
| 404 | KY | 0.805 |
| 405 | KY | 0.811 |
| 406 | KY | 0.801 |
| 407 | KY | 0.774 |
| 408 | KY | 0.774 |
| 409 | KY | 0.774 |
| 410 | KY | 0.800 |
| 411 | KY | 0.836 |
| *** | | 0.000 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| | | i Factors (w |
|-----------|---------|--------------|
| U.S. Area | Factors | |
| 412 | KY | 0.801 |
| 413 | KY | 0.774 |
| 414 | KY | 0.774 |
| 415 | KY | 0.774 |
| 416 | KY | 0.774 |
| 417 | KY | 0.774 |
| 418 | KY | 0.774 |
| 420 | KY | 0.774 |
| 421 | KY | 0.801 |
| 421 | KY | 0.801 |
| | | |
| 423 | KY | 0.777 |
| 424 | KY | 0.795 |
| 425 | KY | 0.774 |
| 426 | KY | 0.774 |
| 427 | KY | 0.774 |
| 430 | ОН | 0.744 |
| 431 | ОН | 0.745 |
| 432 | ОН | 0.748 |
| 433 | ОН | 0.729 |
| 434 | ОН | 0.796 |
| 435 | ОН | 0.789 |
| 436 | ОН | 0.878 |
| 437 | ОН | 0.698 |
| | | |
| 438 | OH | 0.729 |
| 439 | ОН | 0.816 |
| 440 | ОН | 0.869 |
| 441 | ОН | 0.902 |
| 442 | ОН | 0.835 |
| 443 | ОН | 0.837 |
| 444 | ОН | 0.811 |
| 445 | ОН | 0.810 |
| 446 | ОН | 0.765 |
| 447 | ОН | 0.761 |
| 448 | ОН | 0.729 |
| 449 | ОН | 0.727 |
| 450 | ОН | 0.730 |
| 451 | OH | 0.760 |
| 452 | OH | 0.700 |
| | | |
| 453 | OH | 0.761 |
| 454 | OH | 0.773 |
| 455 | ОН | 0.773 |
| 456 | ОН | 0.709 |
| 457 | ОН | 0.746 |
| 458 | ОН | 0.701 |
| 459 | ОН | 0.773 |
| 460 | IN | 0.784 |
| 461 | IN | 0.778 |
| 462 | IN | 0.788 |
| 463 | IN | 0.794 |
| 464 | IN | 0.831 |
| 465 | IN | 0.743 |
| 466 | IN | 0.812 |
| 467 | IN | 0.691 |
| | IN | 0.730 |
| 468 | | |
| 469 | IN | 0.699 |
| 470 | IN | 0.709 |
| 471 | IN | 0.821 |
| 472 | IN | 0.721 |
| 473 | IN | 0.707 |
| 474 | IN | 0.738 |
| 475 | IN | 0.685 |
| 476 | IN | 0.709 |
| 477 | IN | 0.722 |
| 478 | IN | 0.748 |
| 479 | IN | 0.705 |
| 480 | MI | 0.703 |
| 481 | MI | 0.924 |
| 701 | IVII | 0.917 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| IABLE C C | | iois (wei |
|-------------|----------|----------------|
| U.S. Area F | | |
| 482 | MI | 0.960 |
| 483 | MI | 0.924 |
| 484 | MI | 0.817 |
| 485 | MI | 0.819 |
| 486 | MI | 0.776 |
| 487 | MI | 0.762 |
| 488 | MI | 0.754 |
| 489 | MI | 0.762 |
| 490 491 | MI MI | 0.759 0.759 |
| | MI | 0.759 |
| 492 493 | MI | |
| 493 | MI | 0.735 0.735 |
| 494 | MI | 0.735 |
| 496 | MI | 0.708 |
| 490 | MI | 0.735 |
| 498 | MI | 0.708 |
| 499 | MI | 0.735 |
| 500 | IA | 0.708 |
| 501 | IA | 0.705 |
| 502 | IA | 0.747 |
| 503 | IA | 0.747 |
| 504 | IA | 0.699 |
| 505 | IA | 0.699 |
| 506 | IA IA | 0.715 |
| 507 | IA IA | 0.713 |
| 508 | IA IA | 0.752 |
| 509 | IA IA | 0.725 |
| 510 | IA IA | 0.723 |
| 510 | IA IA | 0.704 |
| 512 | IA IA | 0.721 |
| 512 | IA IA | 0.699 |
| 513 | IA IA | 0.699 |
| 515 | IA | 0.760 |
| 516 | IA | 0.699 |
| 520 | IA | 0.709 |
| 521 | IA | 0.699 |
| 522 | IA | 0.751 |
| 523 | IA | 0.714 |
| 524 | IA | 0.715 |
| 525 | IA | 0.699 |
| 526 | IA | 0.699 |
| 527 | IA | 0.742 |
| 528 | IA | 0.750 |
| 530 | WI | 0.814 |
| 531 | WI | 0.841 |
| 532 | WI | 0.899 |
| 534 | WI | 0.826 |
| 535 | WI | 0.740 |
| 537 | WI | 0.840 |
| 538 | WI | 0.734 |
| 539 | WI | 0.734 |
| 540 | WI | 0.782 |
| 541 | WI | 0.736 |
| 542 | WI | 0.733 |
| 543 | WI | 0.726 |
| 544 | WI | 0.695 |
| 545 | WI | 0.734 |
| 546 | WI | 0.731 |
| 547 | WI | 0.716 |
| 548 | WI | 0.745 |
| 549 | WI | 0.705 |
| 550 | MN | 0.778 |
| 551 | MN | 0.821 |
| 553 | MN | 0.787 |
| 554 | MN | 0.821 |
| 555 | MN | 0.794 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| | cont Area | ractors (v |
|-----------|-----------|------------|
| U.S. Area | Factors | |
| 556 | MN | 0.735 |
| 557 | MN | 0.757 |
| 558 | MN | 0.778 |
| 559 | MN | 0.826 |
| 560 | MN | 0.700 |
| 561 | MN | 0.735 |
| 562 | MN | 0.699 |
| 563 | MN | 0.695 |
| 564 | MN | 0.699 |
| | MN | |
| 565 | | 0.741 |
| 566 | MN | 0.735 |
| 567 | MN | 0.771 |
| 570 | SD | 0.728 |
| 571 | SD | 0.743 |
| 572 | SD | 0.723 |
| 573 | SD | 0.723 |
| 574 | SD | 0.723 |
| 575 | SD | 0.723 |
| 576 | SD | 0.723 |
| 577 | SD | 0.734 |
| 580 | ND | 0.712 |
| 581 | ND | 0.713 |
| 582 | ND | 0.713 |
| 583 | | 0.722 |
| | ND | |
| 584 | ND | 0.711 |
| 585 | ND | 0.726 |
| 586 | ND | 0.712 |
| 587 | ND | 0.710 |
| 588 | ND | 0.710 |
| 590 | MT | 0.698 |
| 591 | MT | 0.724 |
| 592 | MT | 0.692 |
| 593 | MT | 0.692 |
| 594 | MT | 0.677 |
| 595 | MT | 0.692 |
| 596 | MT | 0.692 |
| 597 | MT | 0.656 |
| 598 | MT | 0.703 |
| 599 | MT | 0.692 |
| 600 | IL | 0.957 |
| 601 | IL | 0.957 |
| 602 | IL | 0.989 |
| 603 | IL | 0.989 |
| 604 | IL | 0.956 |
| 605 | IL | 0.955 |
| 606 | IL | 1.025 |
| | | |
| 607 | IL | 0.989 |
| 608 | IL | 1.025 |
| 609 | IL | 0.806 |
| 610 | IL | 0.719 |
| 611 | IL | 0.776 |
| 612 | IL | 0.712 |
| 613 | IL | 0.735 |
| 614 | IL | 0.738 |
| 615 | IL | 0.778 |
| 616 | IL | 0.792 |
| 617 | IL | 0.749 |
| 618 | IL | 0.751 |
| 619 | IL | 0.735 |
| 620 | IL | 0.819 |
| 622 | IL | 0.829 |
| 623 | IL | 0.735 |
| 624 | IL | 0.699 |
| 625 | IL IL | 0.099 |
| | IL IL | |
| 626 | | 0.706 |
| 627 | IL II | 0.792 |
| 628 | IL | 0.699 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| | ont Area | ractors (|
|-------------|----------|-----------|
| U.S. Area F | actors | |
| 629 | IL | 0.699 |
| 630 | MO | 0.925 |
| 631 | MO | 0.894 |
| 633 | MO | 0.888 |
| 634 | MO | 0.763 |
| 635 | MO | 0.763 |
| 636 | MO | 0.763 |
| 637 | MO | 0.763 |
| 638 | МО | 0.727 |
| 639 | MO | 0.727 |
| 640 | MO | 0.866 |
| 641 | MO | 0.901 |
| 644 | MO | 0.804 |
| 645 | MO | 0.804 |
| | | |
| 646 | MO | 0.763 |
| 647 | MO | 0.776 |
| 648 | MO | 0.794 |
| 649 | MO | 0.901 |
| 650 | MO | 0.767 |
| 651 | MO | 0.763 |
| 652 | MO | 0.810 |
| 653 | MO | 0.763 |
| 654 | MO | 0.763 |
| 655 | MO | 0.763 |
| 656 | MO | 0.760 |
| 657 | MO | 0.755 |
| 658 | MO | 0.744 |
| 660 | KS | 0.767 |
| 661 | KS | 0.847 |
| 662 | KS | 0.870 |
| 664 | KS | 0.750 |
| 665 | KS | 0.713 |
| 666 | KS | 0.768 |
| 667 | KS | 0.712 |
| 668 | KS | 0.712 |
| | KS | 0.712 |
| 669 | | |
| 670 | KS | 0.741 |
| 671 | KS | 0.770 |
| 672 | KS | 0.819 |
| 673 | KS | 0.748 |
| 674 | KS | 0.712 |
| 675 | KS | 0.712 |
| 676 | KS | 0.712 |
| 677 | KS | 0.748 |
| 678 | KS | 0.748 |
| 679 | KS | 0.748 |
| 680 | NE | 0.804 |
| 681 | NE | 0.835 |
| 683 | NE | 0.760 |
| 684 | NE | 0.761 |
| 685 | NE | 0.765 |
| 686 | NE | 0.718 |
| 687 | NE | 0.718 |
| 688 | NE | 0.718 |
| 689 | NE | 0.718 |
| 690 | NE | 0.754 |
| | NE | 0.734 |
| 691 | | |
| 692 | NE | 0.754 |
| 693 | NE | 0.754 |
| 700 | LA | 1.098 |
| 701 | LA | 1.098 |
| 703 | LA | 0.885 |
| 704 | LA | 0.962 |
| 705 | LA | 0.850 |
| 706 | LA | 0.877 |
| 707 | LA | 0.867 |
| 708 | LA | 0.856 |
| | | |

TABLE C cont. - Area Factors (weighted average by enrollment)

| ILC Arros I | | (V |
|-------------|----------|----------------|
| U.S. Area F | | 0.004 |
| 710 | LA | 0.904 |
| 711 712 | LA LA | 0.936 0.880 |
| 712 | LA | 0.851 |
| 713 | LA | 0.857 |
| | | |
| 716 717 | AR AR | 0.735 |
| 717 | AR | 0.755 0.779 |
| 719 | AR | 0.779 |
| 719 | AR | 0.755 |
| 721 | AR | 0.793 |
| 722 | AR | 0.793 |
| 723 | AR | 0.020 |
| 724 | AR | 0.717 |
| 725 | AR | 0.755 |
| 726 | AR | 0.719 |
| 727 | AR | 0.704 |
| 728 | AR | 0.755 |
| 729 | AR | 0.750 |
| 730 | OK | 0.791 |
| 731 | OK | 0.824 |
| 733 | TX | 0.823 |
| 734 | ок | 0.776 |
| 735 | OK | 0.795 |
| 736 | OK | 0.776 |
| 737 | OK | 0.811 |
| 738 | OK | 0.776 |
| 739 | ОК | 0.776 |
| 740 | OK | 0.761 |
| 741 | OK | 0.754 |
| 743 | OK | 0.776 |
| 744 | OK | 0.773 |
| 745 | OK | 0.776 |
| 746 | OK | 0.775 |
| 747 | OK | 0.776 |
| 748 | OK | 0.784 |
| 749 | OK | 0.782 |
| 750 | TX | 0.923 |
| 751 | TX | 0.889 |
| 752 | TX | 0.925 |
| 753 | TX | 0.925 |
| 754 | TX | 0.834 |
| 755 | TX | 0.861 |
| 756 | TX | 0.852 0.909 |
| 757 758 | TX TX | 0.820 |
| 759 | TX | 0.820 |
| 760 | TX | 0.750 |
| 761 | TX | 0.883 |
| 762 | TX | 0.877 |
| 763 | TX | 0.822 |
| 764 | TX | 0.820 |
| 765 | TX | 0.809 |
| 766 | TX | 0.824 |
| 767 | TX | 0.825 |
| 768 | TX | 0.820 |
| 769 | TX | 0.830 |
| 770 | TX | 1.013 |
| 771 | TX | 1.040 |
| 772 | TX | 1.013 |
| 773 | TX | 0.967 |
| 774 | TX | 0.967 |
| 775 | TX | 0.993 |
| 776 | TX | 1.007 |
| 777 | TX | 0.979 |
| 778 | TX | 0.855 |
| 779 | TX | 0.864 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| TABLE C | ont Area | Factors (weight |
|-------------|----------|-----------------|
| U.S. Area I | Factors | |
| 780 | TX | 0.824 |
| 781 | TX | 0.807 |
| 782 | TX | 0.804 |
| 783 | TX | 0.858 |
| 784 | TX | 0.901 |
| | | |
| 785 | TX | 0.859 |
| 786 | TX | 0.823 |
| 787 | TX | 0.823 |
| 788 | TX | 0.820 |
| 789 | TX | 0.821 |
| 790 | TX | 0.799 |
| 791 | TX | 0.833 |
| 792 | TX | 0.820 |
| 793 | TX | 0.852 |
| 794 | TX | 1.001 |
| | | |
| 795 | TX | 0.820 |
| 796 | TX | 0.821 |
| 797 | TX | 0.809 |
| 798 | TX | 0.872 |
| 799 | TX | 0.899 |
| 800 | CO | 0.806 |
| 801 | СО | 0.808 |
| 802 | CO | 0.833 |
| 803 | CO | 0.779 |
| | | |
| 804 | CO | 0.793 |
| 805 | CO | 0.733 |
| 806 | CO | 0.749 |
| 807 | CO | 0.739 |
| 808 | CO | 0.741 |
| 809 | CO | 0.742 |
| 810 | СО | 0.804 |
| 811 | CO | 0.739 |
| 812 | CO | 0.739 |
| | | |
| 813 | CO | 0.739 |
| 814 | CO | 0.739 |
| 815 | СО | 0.763 |
| 816 | CO | 0.740 |
| 820 | WY | 0.688 |
| 821 | WY | 0.722 |
| 822 | WY | 0.686 |
| 823 | WY | 0.686 |
| 824 | WY | 0.686 |
| 825 | WY | 0.686 |
| 826 | WY | 0.741 |
| | | |
| 827 | WY | 0.686 |
| 828 | WY | 0.686 |
| 829 | WY | 0.686 |
| 830 | WY | 0.686 |
| 831 | WY | 0.686 |
| 832 | ID | 0.673 |
| 833 | ID | 0.664 |
| 834 | ID | 0.664 |
| 835 | ID | 0.664 |
| 836 | ID | 0.668 |
| | | |
| 837 | ID | 0.670 |
| 838 | ID | 0.664 |
| 840 | UT | 0.715 |
| 841 | UT | 0.726 |
| 842 | UT | 0.690 |
| 843 | UT | 0.651 |
| 844 | UT | 0.690 |
| 845 | UT | 0.644 |
| 846 | UT | 0.696 |
| | | |
| 847 | UT | 0.648 |
| 850 | AZ | 0.920 |
| 852 | AZ | 0.920 |
| 853 | AZ | 0.912 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| ILC Area F | | CIOIS (WEI |
|-------------|----|------------|
| U.S. Area F | | |
| 855 | AZ | 0.918 |
| 856 | AZ | 0.899 |
| 857 | AZ | 0.867 |
| 859 | AZ | 0.918 |
| 860 | AZ | 0.858 |
| 863 | AZ | 0.910 |
| 864 | AZ | 0.965 |
| 865 | AZ | 0.918 |
| 870 | NM | 0.741 |
| 871 | NM | 0.733 |
| 872 | NM | 0.733 |
| | | |
| 873 | NM | 0.766 |
| 874 | NM | 0.766 |
| 875 | NM | 0.750 |
| 877 | NM | 0.766 |
| 878 | NM | 0.766 |
| 879 | NM | 0.765 |
| 880 | NM | 0.737 |
| 881 | NM | 0.766 |
| 882 | NM | 0.766 |
| 883 | NM | 0.766 |
| 884 | NM | 0.766 |
| 885 | TX | 0.899 |
| | | |
| 889 | NV | 1.028 |
| 890 | NV | 1.026 |
| 891 | NV | 1.028 |
| 893 | NV | 0.884 |
| 894 | NV | 0.947 |
| 895 | NV | 0.981 |
| 897 | NV | 0.884 |
| 898 | NV | 0.852 |
| 900 | CA | 1.280 |
| 901 | CA | 1.280 |
| 902 | CA | 1.280 |
| 903 | CA | 1.280 |
| 904 | CA | 1.280 |
| | | |
| 905 | CA | 1.258 |
| 906 | CA | 1.246 |
| 907 | CA | 1.255 |
| 908 | CA | 1.258 |
| 909 | CA | 1.258 |
| 910 | CA | 1.258 |
| 911 | CA | 1.258 |
| 912 | CA | 1.258 |
| 913 | CA | 1.247 |
| 914 | CA | 1.258 |
| 915 | CA | 1.258 |
| 916 | CA | 1.258 |
| 917 | CA | 1.159 |
| 918 | CA | 1.235 |
| | | |
| 919 | CA | 1.159 |
| 920 | CA | 1.006 |
| 921 | CA | 1.006 |
| 922 | CA | 0.958 |
| 923 | CA | 0.948 |
| 924 | CA | 0.948 |
| 925 | CA | 0.984 |
| 926 | CA | 1.119 |
| 927 | CA | 1.119 |
| 928 | CA | 1.159 |
| 930 | CA | 0.990 |
| | | |
| 931 | CA | 1.023 |
| 932 | CA | 0.911 |
| 933 | CA | 0.902 |
| 934 | CA | 1.023 |
| 935 | CA | 1.001 |
| 936 | CA | 0.908 |

TABLE C cont. - Area Factors (weighted average by enrollment)

| TABLE C cont Area Factors (| | | | |
|-----------------------------|----|-------|--|--|
| U.S. Area Factors | | | | |
| 937 | CA | 0.905 | | |
| 938 | CA | 0.905 | | |
| 939 | CA | 0.958 | | |
| 940 | CA | 1.162 | | |
| 941 | CA | 1.325 | | |
| 942 | CA | 1.176 | | |
| 943 | CA | 1.121 | | |
| 944 | CA | 1.199 | | |
| 945 | CA | 1.164 | | |
| 946 | CA | 1.166 | | |
| 947 | CA | 1.166 | | |
| 948 | CA | 1.166 | | |
| 949 | CA | 1.124 | | |
| 950 | CA | 1.015 | | |
| 951 | CA | 1.051 | | |
| 952 | CA | 1.024 | | |
| 953 | CA | 1.033 | | |
| 954 | CA | 0.951 | | |
| 955 | CA | 0.919 | | |
| 956 | CA | 0.993 | | |
| 957 | CA | 0.992 | | |
| 958 | CA | 0.992 | | |
| 959 | CA | 0.923 | | |
| 960 | CA | 1.031 | | |
| 961 | CA | 0.937 | | |
| 965 | AK | 1.050 | | |
| 967 | HI | 0.859 | | |
| 968 | HI | 0.878 | | |
| 970 | OR | 0.742 | | |
| 971 | OR | 0.740 | | |
| 972 | OR | 0.768 | | |
| 973 | OR | 0.739 | | |
| 974 | OR | 0.768 | | |
| 975 | OR | 0.769 | | |
| 976 | OR | 0.722 | | |
| 977 | OR | 0.722 | | |
| 978 | OR | 0.722 | | |
| 979 | OR | 0.722 | | |
| 980 | WA | 0.770 | | |
| 981 | WA | 0.769 | | |
| 982 | WA | 0.756 | | |
| 983 | WA | 0.711 | | |
| 984 | WA | 0.714 | | |
| 985 | WA | 0.718 | | |
| 986 | WA | 0.711 | | |
| 987 | WA | 0.900 | | |
| 988 | WA | 0.695 | | |
| 989 | WA | 0.702 | | |
| 990 | WA | 0.704 | | |
| 991 | WA | 0.695 | | |
| 992 | WA | 0.706 | | |
| 993 | WA | 0.714 | | |
| 994 | WA | 0.695 | | |
| 995 | AK | 1.048 | | |
| 996 | AK | 1.050 | | |
| 997 | AK | 1.050 | | |
| | | | | |

AK

ΑK

1.050

1.050

998

999

TABLE D - Medical Evacuation (interpolated interim values)

| Option | Benefit | Factor |
|--------|--------------|-----------|
| 1 | \$0 | 0.982 |
| 2 | \$50,000 | 0.990 |
| 3 | \$100,000 | 1.000 |
| 4 | \$150,000 | 1.003 |
| 5 | \$200,000 | 1.004 |
| 6 | \$250,000 | 1.006 |
| 7 | \$300,000 | 1.008 |
| 8 | \$350,000 | 1.009 |
| 9 | \$400,000 | 1.010 |
| 10 | \$450,000 | 1.011 |
| 11 | \$500,000 | 1.012 |
| 12 | \$550,000 | 1.013 |
| 13 | \$600,000 | 1.014 |
| 14 | \$650,000 | 1.015 |
| 15 | \$700,000 | 1.016 |
| 16 | \$750,000 | 1.017 |
| 17 | \$800,000 | 1.018 |
| 18 | \$850,000 | 1.019 |
| 19 | \$900,000 | 1.020 |
| 20 | \$950,000 | 1.021 |
| 21 | \$1,000,000 | 1.022 |
| 22 | \$1,000,001+ | Not Avail |

TABLE E - Credibility Factors

| Number of Participants | | Range of | Credibility | |
|------------------------|---------|----------|-------------|---------|
| From | То | Low | High | Formula |
| 50 | 74 | 0% | 30% | 17% |
| 75 | 99 | 0% | 35% | 24% |
| 100 | 124 | 0% | 40% | 29% |
| 125 | 149 | 0% | 45% | 33% |
| 150 | 174 | 0% | 50% | 37% |
| 175 | 199 | 5% | 55% | 40% |
| 200 | 224 | 10% | 60% | 42% |
| 225 | 249 | 15% | 65% | 45% |
| 250 | 274 | 20% | 70% | 47% |
| 275 | 299 | 25% | 75% | 49% |
| 300 | 324 | 30% | 80% | 50% |
| 325 | 349 | 35% | 85% | 52% |
| 350 | 374 | 40% | 90% | 53% |
| 375 | 399 | 45% | 95% | 55% |
| 400 | 424 | 50% | 100% | 56% |
| 425 | or more | 50% | 100% | 57% |

SERFF Tracking #: BCSF-130097000 State Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Supporting Document Schedules

| Bypassed - Item: | |
|--|---|
| | Actuarial Memorandum |
| Bypass Reason: | See Actuarial Memo and Certification |
| Attachment(s): | |
| Item Status: | |
| Status Date: | |
| Satisfied - Item: | A structural Management and Contifications |
| | Actuarial Memorandum and Certifications |
| Comments: | NET JEL E D. A. A. M |
| Attachment(s): | VT_4EL_ExPat_Act_Memo_revised_20150618.pdf |
| Item Status: | |
| Status Date: | |
| Bypassed - Item: | Civil Union Rating Requirements |
| Bypass Reason: | Not Applicable |
| Attachment(s): | |
| Item Status: | |
| Status Date: | |
| otatas pate. | |
| | Consumer Disclosure Form |
| Bypassed - Item: | Consumer Disclosure Form Not Applicable |
| Bypassed - Item: Bypass Reason: | Consumer Disclosure Form Not Applicable |
| Bypassed - Item: | |
| Bypassed - Item: Bypass Reason: Attachment(s): | |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: | Not Applicable |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: | |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: | Not Applicable Filing Compliance Certification |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: | Not Applicable |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: Attachment(s): | Not Applicable Filing Compliance Certification |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: Attachment(s): Item Status: Status Date: | Not Applicable Filing Compliance Certification VT Certification of Compliance.pdf |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: Attachment(s): Item Status: Status Date: Bypassed - Item: | Not Applicable Filing Compliance Certification VT Certification of Compliance.pdf Third Party Filing Authorization |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: Attachment(s): Item Status: Status Date: Bypassed - Item: Bypass Reason: | Not Applicable Filing Compliance Certification VT Certification of Compliance.pdf |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: Attachment(s): Item Status: Status Date: Bypassed - Item: Bypass Reason: Attachment(s): | Not Applicable Filing Compliance Certification VT Certification of Compliance.pdf Third Party Filing Authorization |
| Bypassed - Item: Bypass Reason: Attachment(s): Item Status: Status Date: Satisfied - Item: Comments: Attachment(s): Item Status: Status Date: Bypassed - Item: Bypass Reason: | Not Applicable Filing Compliance Certification VT Certification of Compliance.pdf Third Party Filing Authorization |

| SERFF Tracking #: | BCSF-130097000 | State Tracking #: | | Company Tracking #: | 54.1201 VT (EX-PAT RATES) |
|----------------------|-----------------|---|--------------------------------|--------------------------------|---------------------------------------|
| State: | VermontGMCB | | Filing Company: | 4 Ever Life Insurar | nce Company |
| TOI/Sub-TOI: | H16G Group Hea | lth - Major Medical/H16G.002C La | arge Group Only - Other | | |
| Product Name: | Group Major Med | lical - Ex-Pat (Rates) | | | |
| Project Name/Number: | Group Major Med | ical - Ex Pat (Rates)/54.1201 VT | (Ex-Pat Rates) | | |
| Bypassed - Item: | Ur | nified Rate Review Templa | te | | |
| Bypass Reason: | No | ot Applicable | | | |
| Attachment(s): | | | | | |
| Item Status: | | | | | |
| Status Date: | | | | | |
| Satisfied - Item: | VT | 4EL ExPat forms BCSF-1 | 27963460-approved Filing | | |
| Comments: | | | | | |
| Attachment(s): | V7 | Γ 4EL ExPat forms BCSF-1 | 27963460-approved.pdf | | |
| Item Status: | | | | | |
| Status Date: | | | | | |
| Satisfied - Item: | E | KCEL COPY - RATE MANU | JAL | | |
| | | | BCSF-129684270, a copy o | | · |
| Comments: | | II number/calucation type or ersion" | documents within the filing mu | ist include the (.xis) version | n along with the corresponding (.pdf) |
| | lt v | was unclear if this should b | e attached to the Rate/Rule t | ab, so we attached it here | |
| Attachment(s): | V7 | Γ Expat Rat Manual 2015_0 | 06_18.xlsx | | |
| Item Status: | | | | | |
| Status Date: | | | | | |
| Satisfied - Item: | Ot | ojection Response Letter | | | |
| Comments: | | | | | |
| Attachment(s): | V7 | Expat BCSF-130097000 | 20150611 objection response | e.pdf | |
| Item Status: | | | | | |
| Status Date: | | | | | |

SERFF Tracking #: BCSF-130097000 State Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Attachment VT Expat Rat Manual 2015_06_18.xlsx is not a PDF document and cannot be reproduced here.

Item 1. Scope & Purpose

This is a new rate filing. The Actuarial Memorandum has been prepared to accompany the previously approved captioned forms filing.

Item 2. Benefit Description

The program is an expatriate health plan that provides hospital/medical/surgical expense benefits to employers for the benefit of employees who are traveling outside the United States for extended periods of time for employer business purposes (generally 3 months or more).

All plans are subject to deductibles and coinsurance and have maximum benefits and other limits consistent with PPACA.

The policy has in-network and out-of-network benefits for coverage in the US and uses a PPO network for these benefits.

Item 3. Renewability

The Policy will continue inforce while the required premiums are paid until the Policy is terminated by either the policyholder or the insurer as allowed in the Policy.

Item 4. Applicability

This filing applies to all new issues and subsequent renewals. There are no existing insureds under this form.

Item 5. Morbidity

This morbidity basis shown in the attached Rate Manual is based on the nationwide experience for this block of business that was written in other states. Current nationwide membership is around 16,000 members and the experienced loss ratio has averaged 69.5% over the last three years.

(\$000)

| (\$000) | | | |
|---------|----------------|-----------------|------------|
| Year | Earned Premium | Incurred Claims | Loss Ratio |
| 2012 | 17,011 | 12,064 | 70.9% |
| 2013 | 58,868 | 41,739 | 70.9% |
| 2014 | 60,216 | 40,826 | 67.8% |
| Total | 136,095 | 94,629 | 69.5% |

Item 6. Mortality

Mortality is based on US population mortality.

Item 7. Persistency

Given the short term nature of the product, there is no specific persistency assumption used in developing the claim costs.

Item 8. Expenses and Commissions

| Premium | 100.0% |
|-----------------------------|--------|
| Administration | 18.5% |
| Average Commissions | 8.0% |
| Premium Taxes | 2.0% |
| Contingency and Risk Margin | 6.0% |
| Total | 34.5% |

The actual commissions will vary between 0% and 15%. The retention net of commissions also varies by group size shown in the following table.

| Group Size | Retention | Distribution |
|---------------|-----------|--------------|
| 1 | 38.0% | 5.0% |
| 2-399 | 36.0% | 15.0% |
| 400+ | 24.0% | 80.0% |
| avg | 26.5% | |

Item 9. Marketing Method

Marketing will be to employer groups either through direct response or using agents and brokers.

Item 10. Underwriting

The policies are guarantee issue with no health questions. Policies may be experience rated. The rate manual shows an experience rating calculation. A group can be declined if the travel is to a country of civil unrest or hazardous.

Item 11. Premium Classes

For each employer, rates vary only by tier. The rate is determined by taking the average rate based on the age and gender of the employees, benefit plan provisions (deductible, coinsurance, and lifetime maximum, etc.), area, etc.

Item 12. Issue Age Limits

None.

Item 13. Area Factors

Rates vary by zip code and nationality as shown in the rate manual.

Item 14. Average Annual Premium

The average annual premium is shown in the Rate Manual worksheet.

Item 15. Number of Insureds

The Company has no insureds at the present time as this is the initial filing.

Item 16. Premium Modalization Rules

Premiums are stated as monthly.

Item 17. Trend Assumption

Medical trend is 10.3% annual. Dental trend is 6 % annual. Vision trend is 4% annual.

Item 18. Claim Liability and Reserves

Claim Reserves and Liabilities will be established by a combination of Lag Studies, case level reserves, and analysis of claim inventories.

Item 19. Active Life Reserves

No Active Life Reserves will be held for this coverage.

Item 20. Minimum Required Loss Ratio

The minimum required loss ratio for this form is 65.5%.

The EXPATRIATE HEALTH COVERAGE CLARIFICATION ACT OF 2014 generally exempts expatriate health plans from the MLR requirements of PPACA for plans written on or after 7/1/15. Prior to that, expatriate plans were allowed a 2x factor to the numerator when calculating the MLR, essentially permitting a minimum standard loss ratio of 42.5% for large-groups expatriate plans in order to meet MLR requirements.

Item 21. Distribution of Business

The anticipated distribution of business is shown on the attached Rate Manual worksheet and is used in the calculation of the average premium.

Item 22. Contingency and Risk Margin

The expected margin for profit and contingencies is 6.0% of premium.

Item 23. Experience – Past and Future

As this is a new product, no historical experience is available in this state.

Item 24. Anticipated Loss Ratio

The anticipated loss ratio is 65.5%. The anticipated loss ratio for each year is 65.5%

Item 25. History of Rate Adjustments

This is a new rate filing. There have been no rate adjustments.

Item 26. Proposed Effective Date

These rates are to be effective coincident with approval.

Item 27. Actuarial Certification

I, Randall Jones, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify to the best of my knowledge and judgment, this Actuarial Memorandum and the entire rate filing is in compliance with the applicable laws of the State and with the rules of the Department of Insurance, and complies with Actuarial Standard of Practice No. 8 "Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits" as adopted by the Actuarial Standards Board, and that the benefits provided are reasonable in relation to the proposed premiums based on the standards described above. The premium schedule is not excessive, inadequate or unfairly discriminatory. This rate filing is in full compliance with the Expatriate Health Coverage Clarification Act of 2014.

Randall S. Jones, FSA, MAAA

Randall & Jack

President

Sierra Actuarial Services, Inc.

June 18, 2015

4 Ever Life Insurance Company

Oakbrook Terrace, IL 60181

Certification of Compliance

RE: Group Major Medical Policy Form 54.1201 ER VT, et al.

- I, Linda Hickok, Vice President, certify to the best of my knowledge and belief that the attached forms comply with Vermont law, specifically the accident and health requirements of Regulation 80-1, and that:
- (1) only large employer-employee groups meeting the standards of 8 VSA § 4079(1) will be allowed to purchase this product; and
- (2) the forms will be issued only to large employer-employee groups meeting the standards of 8 VSA §
- 4079(1). I further certify to the best of my knowledge and belief that the attached forms comply with:
- (1) Regulation H-2009-03 (NILS designation H-09-3), the Consumer Protection and Quality Requirements for Managed Care Organizations;
- (2) Regulation H-2008-01 (NILS designation H-08-1), the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES); and
- (3) the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA).

| Signature: | Lenda W. Nickok | |
|------------|-----------------|--|
| | | |
| Date: | 6/1/2015 | |

SERFF Tracking #: BCSF-127963460 State Tracking #: 58065

Company Tracking #: MET 54.1201 VT

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Filing at a Glance

Company: 4 Ever Life Insurance Company

Product Name: Group Major Medical

State: Vermont

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002C Large Group Only - Other

Filing Type: Form

Date Submitted: 01/06/2012

SERFF Tr Num: BCSF-127963460 SERFF Status: Closed-Approved

State Tr Num: 58065 State Status: Approved

Co Tr Num: MET 54.1201 VT

Co Status:

Implementation On Approval

Date Requested:

Author(s): Susan Coulter, Linda Hickok, Diane Sowell, Craig Ardagh

Reviewer(s): David Milliken (primary)

Disposition Date: 07/17/2012
Disposition Status: Approved

Implementation Date:

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

General Information

Project Name: MET Group Major Medical - Outbound Status of Filing in Domicile: Not Filed

Project Number: MET 54.1201 VT F

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Large Group Market Type: Employer Overall Rate Impact:

Filing Status Changed: 07/17/2012 Company Status Changed:

State Status Changed: 07/17/2012 Deemer Date:

Created By: Susan Coulter Submitted By: Susan Coulter

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

Include Exchange Intentions: No

Filing Description:

RE:4 Ever Life Insurance Company - NAIC # 023-80985 - FEIN 36-2149353

FORMS:Group Policy Form 54.1201 ER VT
Certificate of Coverage Form Number 54.1301 ER VT
Group Application Form 64.1101 ER
Outline of Coverage Form 54.1217 VT

4 Ever Life Insurance Company is filing the attached forms and rates for your review and approval.

A similar program was submitted on May 12, 2011 for the Company's sister company BCS Insurance Company (BCSF-127165324). All changes made to date in the BCS forms have been incorporated into the attached 4 Ever Life forms.

The program provides hospital/medical/surgical expense benefits and will be issued only to large employer groups meeting the standards of Vermont Insurance Code T. 8 s 3803. These forms will not be sold to small employer or non-employer groups. This program is for the benefit of employees who are traveling outside the United States for extended periods of time for employer business purposes. It may also continue to cover those employees when temporarily back in the United States at the option of the employer. The carrier provides a list of credentialed providers when an insured is abroad to ensure access to qualified providers. There is no network used and no network differential for providers outside the United States. A Blue Cross / Blue Shield PPO network is used when a person is state side. Coverage is provided for employees and their dependents and is available on a contributory or non-contributory basis.

An employer will complete Group Application Form 54.1101 ER. Policy Form 54.1201 ER VT will then be issued to the employer as the policyholder. Certificate Form Number 54.1301 ER VT is the document that will be issued to an Insured Person. The provisions of the certificate are incorporated into the policy to form the entire contract. Please see the attached Statements of Variability for a complete explanation of the variables shown in these forms.

Coverage is available on a guaranteed issue basis to those who enroll.

Rates for this program will be submitted under separate cover once the forms have been approved.

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

These forms are new and will not supersede any forms on file with the Department.

If you have any questions, please call me at (609) 443-7540 or email me at frank@coulter-and-associates.com. Otherwise we look forward to your approval.

Sincerely,

Frank Cripps

Senior Contracts and Compliance Consultant

Company and Contact

Filing Contact Information

Susan Coulter, Contract Analyst susan@coulter-and-associates.com

 379 Princeton-Hightstown Road
 609-443-7540 [Phone]

 Suite 15
 609-443-4103 [FAX]

Cranbury, NJ 08512

Filing Company Information

4 Ever Life Insurance Company CoCode: 80985 State of Domicile: Illinois

2 Mid America Plaza Group Code: 23 Company Type:

Suite 200 Group Name: State ID Number: 0023-80985

Oakbrook Terrace, IL 60181 FEIN Number: 36-2149353

(630) 472-7842 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No

Fee Explanation: Domicile State Fee (IL) = \$50; VT fee = \$50.00.

Per Company: Yes

CompanyAmountDate ProcessedTransaction #4 Ever Life Insurance Company\$50.0001/06/201255097046

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|----------|----------------|------------|----------------|
| Approved | David Milliken | 07/17/2012 | 07/17/2012 |

Objection Letters and Response Letters

Objection Letters Response Letters

| Status | Created By | Created On | Date Submitted | Responded By | Created On | Date Submitted |
|---------------------------------------|----------------|------------|----------------|---------------|------------|----------------|
| Declined Pending Filer Response | David Milliken | 02/13/2012 | 02/13/2012 | Susan Coulter | 04/19/2012 | 04/19/2012 |

Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|--------------|------------------|---------------|------------|----------------|
| status check | Note To Reviewer | Susan Coulter | 06/14/2012 | 06/14/2012 |

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Disposition

Disposition Date: 07/17/2012

Implementation Date: Status: Approved

HHS Status: HHS Approved

State Review:

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|-------------------------------|-------------------------------------|----------------------|----------------------|
| Supporting Document (revised) | Filing Compliance Certification | | Yes |
| Supporting Document | Filing Compliance Certification | | Yes |
| Supporting Document | Flesch Score Certification | | Yes |
| Supporting Document | Health Administrative Forms | | Yes |
| Supporting Document (revised) | Health Filing Data | | Yes |
| Supporting Document | Health Filing Data | | Yes |
| Supporting Document (revised) | Redlined Copy | | Yes |
| Supporting Document | Redlined Copy | | Yes |
| Supporting Document | Third Party Filing Authorization | | Yes |
| Supporting Document | PPACA Uniform Compliance Summary | | Yes |
| Supporting Document | Responses to 20120213 VT Objections | | Yes |
| Form (revised) | Group Policy | | Yes |
| Form | Group Policy | | Yes |
| Form (revised) | Certificate of Coverage | | Yes |
| Form | Certificate of Coverage | | Yes |
| Form | Group Application | | Yes |
| Form | Outline of Coverage | | Yes |

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Objection Letter

Objection Letter Status Declined Pending Filer Response

Objection Letter Date 02/13/2012
Submitted Date 02/13/2012
Respond By Date 05/14/2012

Dear Susan Coulter,

Introduction:

Dear Susan Coulter: We have reviewed the above captioned, Vermont- specific, large group-only, PPACA-compliant, major medical (MM) expense insurance policy, certificate and related ancillary forms and have the following questions and comments: (1) Thank you for providing the required eligible group compliance certification, however, although Assistant Vice President Linda Hickok's certification identifies 8 VSA § 4079(1) employer-employee groups as the SOLE target market for this product, the SERFF General Information submission text identifies 8 VSA § 3803 (i.e., the life & annuity statute under Chapter 103 of Title 8 rather than the accident and health (A&H) statute under Chapter 107) as the target market groups. Please clarify. (2) PPACA/ACA does not currently, at this time, apply to large group MM products. Is it the insurer's intent to revise this MM product now, for compliance with PPACA/ACA requirements? (3) While this product is clearly intended to be MM insurance, the SERFF submission text identifies this as a "hospital/medical/surgical" product, which is an entirely different animal altogether [Regulation 80-1]. Please clarify. (4) The SERFF submission text also states that under this MM product "There is no network and no network differential for providers outside the United States. A Blue Cross/Blue Shield PPO network is used when a person is state side." Please identify the Blue Cross Blue Shield (BCBS) entity or entities with whom the insurer has contracted to provide coverage for persons while in the USA. (5) The SERFF submission text and certain policy provisions seem to indicate that, in addition to employer-employee groups, the insurer also intends to market this product to "multiple employer trust" (METs) groups. For example, the insurer's "project name" for this product filing is "MET Group Major Medical - Outbound." As you know, single-employer products are very different from multiple-employer products and in some instances are subject to completely different regulatory requirements. Please clarify. (6) Please revise Assistant Vice President Linda Hickok's compliance certification to explicitly certify compliance with federal PPACA/ACA requirements. (7) Your submission text asserts that all of the Department's comments on the BCS Insurance Company's "companion" filing (VFN 54559 see copy of disapproval report attached) have already been addressed in this more recent filing. Please confirm. (8) The "product name" for this product is filed as variable. Why is that? (9) The group policy identifies the product it describes as the "HTH Group Insurance Plan." What does that mean? For example, is "HTH" the name of a purchaser company (employer?) and therefore these forms are being filed on a one case basis rather than for general use? Please clarify. (10) This managed care product's "service area" is (a) filed as 100% variable and (b) described as "{within the United States/outside the United States/anywhere in the world}." Please explain (c) the factors or circumstances that dictate what the service area will be, and (d) whether or not the service area, once designated under an issued policy, can be changed. (11) Why are multiple types of brackets used to identify substantive text filed as variable (e.g., both "hard" [XXX] and "soft" {XXX} brackets) and what is the significance of bold typeface brackets versus non-bold typeface brackets? (12) This two-page "wrap around" policy form contemplates policy administration being performed by a "third party administrator" or TPA. Please (a) verify that this policy will always be administered by a TPA, (b) provide a complete list of TPAs with which the insurer has contracted for the purpose of administering this or similar policies, (c) confirm that the TPA and the insurer and the contractual relationship between the two always, at all times and in all instances, complies with the Department's "VHCURES" regulation [Regulation H-2008-01] and (d) revise Ms. Hickok's compliance certification to explicitly certify compliance with the VHCURES regulation. (13) Is (a) the policy's "incorporation" clause on policy page 2 intended to constitute the mandated "entire contract" provision? [8 VSA § 4065(2), Regulation 80-1 § 3] or (b) is the "agreement" clause on policy page 1 intended to comply with the "entire contract" mandate? Please (c) note that the definition of what constitutes the "entire" contract differs between the two provisions described under (a) and (b) above (for example, one includes "riders and endorsements" in the definition of what constitutes the entire contract, the other does not), (d) provide the VFNs, approval dates and FYI-only copies of ALL of the "endorsements and riders" mentioned in the "incorporation provision" on policy page 2 that the insurer anticipates using to modify this product or that can or might or could be used by the insurer to modify this product, and (e) note that, by law, insurance contracts MUST include an "entire contract" clause [8 VSA § 4065(1), Regulation 80-1 § 3] regardless of the "incorporation" and "agreement" clauses. Please revise accordingly. (14) Please provide the VFN, approval date and an FYI-only copy of the Vermont civil unions rider that is always issued with this product. (15) The group policy cover page includes a "policy term" item; is this product sold as a

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

so-called "limited term" product rather than an auto-annual-renewal "evergreen" policy? (16) All group policies, even the "wrap around" versions, must include all of the standard "boilerplate" provisions required by 8 VSA § 4065 and Regulation 80-1, however this policy form fails to include the majority of those provisions. Please revise accordingly. (17) Due to all of the above the Department is disapproving this filing. The Department will complete its review of this filing on receipt of satisfactory responses to the above. Since the filing is disapproved the insurer has the right to request a formal Department hearing pursuant to 8 VSA § 4062. If a hearing is requested it will be granted within 20 days of receipt of written request, such request to be sent via first class U.S. Mail to the reviewer's attention. If a hearing is desired the insurer should request it within 30 days of its receipt of this disapproval. Sincerely, David Milliken. david.milliken@state.vt.us

Conclusion:

Pursuant to 8 V.S.A § 4062, a hearing will be granted within 20 days upon written request of the insurer. A request to appeal this decision should be submitted to the Department within 30 days of receipt of this disapproval letter. Such request must be sent via first class U.S. Mail to the reviewer's attention.

Sincerely,

David Milliken

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Response Letter

Response Letter Status Submitted to State

Response Letter Date 04/19/2012 Submitted Date 04/19/2012

Dear David Milliken,

Introduction:

Response 1

Comments:

Because of the size of our response, we are attaching it as a separate document under the Supporting Documentation tab.

Changed Items:

| Supporting Document Schedule Item Changes | | | | |
|---|--|--|--|--|
| Satisfied - Item: | Filing Compliance Certification | | | |
| Comments: | | | | |
| Attachment(s): | VT Certificate of Compliance (signed 20120405).pdf | | | |
| Previous Version | | | | |
| Satisfied - Item: | Filing Compliance Certification | | | |
| Comments: | | | | |
| Attachment(s): | VT Certification of Compliance.pdf | | | |

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

| Supporting Document So | hedule Item Changes |
|------------------------|---|
| Satisfied - Item: | Filing Compliance Certification |
| Comments: | |
| Attachment(s): | VT Certificate of Compliance (signed 20120405).pdf |
| Previous Version | |
| Satisfied - Item: | Filing Compliance Certification |
| Comments: | |
| Attachment(s): | VT Certification of Compliance.pdf |
| | |
| Satisfied - Item: | Health Filing Data |
| Comments: | Civil Union requirements have been incorporated into the forms. |
| Attachment(s): | Form 54.1201 ER VT (20120404 SOV).pdf Form Number 54.1301 ER VT (20120404 SOV).pdf |
| Previous Version | |
| Satisfied - Item: | Health Filing Data |
| Comments: | Civil Union requirements have been incorporated into the forms. |
| Attachment(s): | Form 54.1201 ER VT (20120105 SOV).pdf Form Number 54.1301 ER VT (20120105 SOV).pdf |

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

| Supporting Document So | chedule Item Changes |
|-------------------------------|---|
| Satisfied - Item: | Filing Compliance Certification |
| Comments: | |
| Attachment(s): | VT Certificate of Compliance (signed 20120405).pdf |
| Previous Version | |
| Satisfied - Item: | Filing Compliance Certification |
| Comments: | |
| Attachment(s): | VT Certification of Compliance.pdf |
| | |
| Satisfied - Item: | Health Filing Data |
| Comments: | Civil Union requirements have been incorporated into the forms. |
| Attachment(s): | Form 54.1201 ER VT (20120404 SOV).pdf Form Number 54.1301 ER VT (20120404 SOV).pdf |
| Previous Version | |
| Satisfied - Item: | Health Filing Data |
| Comments: | Civil Union requirements have been incorporated into the forms. |
| Attachment(s): | Form 54.1201 ER VT (20120105 SOV).pdf Form Number 54.1301 ER VT (20120105 SOV).pdf |
| | |
| Satisfied - Item: | Redlined Copy |
| Comments: | |
| Attachment(s): | Form 54.1201 ER VT - Policy (20120404 redline).pdf Form Number 54.1301 ER VT - Cert (20120404 redline).pdf |
| Previous Version | |
| Bypassed - Item: | Redlined Copy |
| Bypass Reason: | New form; redlines not required. |
| Attachment(s): | |

Filing Company: 4 Ever Life Insurance Company State: Vermont

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Group Major Medical Product Name:

| MET Group Major Medical - Outbound/MET 54.1201 VT F |
|---|
| nt Schedule Item Changes |
| |
| Filing Compliance Certification |
| VT Contificate of Contribution (singled 20400405) and |
| VT Certificate of Compliance (signed 20120405).pdf |
| |
| Filing Compliance Certification |
| LUTTO VIII VI CO VI |
| VT Certification of Compliance.pdf |
| |
| Health Filing Data |
| Civil Union requirements have been incorporated into the forms. |
| Form 54.1201 ER VT (20120404 SOV).pdf Form Number 54.1301 ER VT (20120404 SOV).pdf |
| |
| Health Filing Data |
| Civil Union requirements have been incorporated into the forms. |
| Form 54.1201 ER VT (20120105 SOV).pdf Form Number 54.1301 ER VT (20120105 SOV).pdf |
| |
| Redlined Copy |
| |
| Form 54.1201 ER VT - Policy (20120404 redline).pdf Form Number 54.1301 ER VT - Cert (20120404 redline).pdf |
| |
| Redlined Copy |
| New form; redlines not required. |
| |
| |
| Responses to 20120213 VT Objections |
| |
| Responses to 20120213 VT Objections.pdf |
| |

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

| Form Sche | Form Schedule Item Changes | | | | | | | |
|-------------|----------------------------|------------------------------|------|---------|-----------------|-------------|---|---|
| Item | Form | Form | Form | Form | Action Specific | Readability | | |
| No. | Name | Number | Туре | Action | Data | Score | Attachments | Submitted |
| 1 | Group Policy | Form 54.1201 ER VT | POL | Initial | | 45.200 | Form 54.1201 ER VT - Policy (20120404 cc).pdf | Date Submitted: 04/19/2012 By: Susan Coulter |
| Previous Ve | ersion | | | | | | | |
| 1 | Group Policy | Form 54.1201 ER VT | POL | Initial | | 45.200 | Form 54.1201 ER VT - Policy (20120105 cc).pdf | Date Submitted: 01/06/2012 By: Susan Coulter |
| 2 | Certificate of Coverage | Form Number 54.1301 ER VT | CER | Initial | | 49.100 | Form Number 54.1301 ER VT - Cert (20120404 cc).pdf | Date Submitted: 04/19/2012 By: Susan Coulter |
| Previous Ve | Previous Version | | | | | | | |
| 2 | Certificate of Coverage | Form Number 54.1301 ER VT | CER | Initial | | 49.100 | Form Number 54.1301 ER VT - Cert (20120105 cc).pdf | Date Submitted: 01/06/2012 By: Susan Coulter |

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,

Susan Coulter

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Note To Reviewer

Created By:

Susan Coulter on 06/14/2012 10:09 AM

Last Edited By:

Susan Coulter

Submitted On:

06/14/2012 10:09 AM

Subject:

status check

Comments:

we are checking on the status of the captioned submission. If you have any additional questions, please let me know. Regards, Susan Coulter

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Form Schedule

| Lead Form Number: Form 54.1201 ER VT | | | | | | | | |
|--------------------------------------|---------------|-------------------------|------------------------------------|------|---------|-----------------|-------------|--|
| Item | Schedule Item | Form | Form | Form | Form | Action Specific | Readability | |
| No. | Status | Name | Number | Туре | Action | Data | Score | Attachments |
| 1 | | Group Policy | Form 54.1201 ER VT | POL | Initial | | 45.200 | Form 54.1201 ER VT - Policy (20120404 cc).pdf |
| 2 | | Certificate of Coverage | Form Number 54.1301 ER VT | CER | Initial | | 49.100 | Form Number 54.1301 ER VT - Cert (20120404 cc).pdf |
| 3 | | Group Application | Form 54.1101 ER | AEF | Initial | | | Form 54.1101 ER - Group Application.pdf |
| 4 | | Outline of Coverage | Form 54.1217 VT | OUT | Initial | | 57.000 | Form 54.1217 VT - Outline of Coverage (20120105 cc).pdf |

Form Type Legend:

| 1 01111 1 9 | pe Legena. | | |
|-------------|---|------|--|
| ADV | Advertising | AEF | Application/Enrollment Form |
| CER | Certificate | CERA | Certificate Amendment, Insert Page, Endorsement or Rider |
| DDP | Data/Declaration Pages FND Funding Agreement (Annuity, Individual | | Funding Agreement (Annuity, Individual and Group) |
| MTX | Matrix | NOC | Notice of Coverage |
| ОТН | Other | OUT | Outline of Coverage |
| PJK | Policy Jacket | POL | Policy/Contract/Fraternal Certificate |
| POLA | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | SCH | Schedule Pages |
| | | | |

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200

Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

[Product Name] MAJOR MEDICAL EXPENSE INSURANCE

POLICYHOLDER: [Employer]

POLICY EFFECTIVE DATE: [Month, Date, Year]

POLICY NUMBER: <###> ("the Policy")

STATE OF DELIVERY: Vermont

ADMINISTRATOR: [Authorized Administrator]

This Policy is a legal contract between the Policyholder and 4 Ever Life Insurance Company (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGRFFMFNT

This Policy, the Certificates issued under the policy, the application(s) of the Policyholder form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by an Insured Person, by the Insurer's Agent, or by any other person are not part of this Policy. Only the Insurer's President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Insured Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

POLICY TERM

Policy Effective Date: <MM/DD/YYYY>
Policy End Date: <MM/DD/YYYY>

Policy Termination Date: The Policy will continue in force for the while the required premiums are paid until the Policy End Date or the Policy is terminated by either the Policyholder or by the Insurer. At least <45 – 90> days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Group's coverage under the Policy may be cancelled at any time after <45 – 90> days written notice mailed or delivered by the Insurer to the Group or by the Group to the Insurer.

If the Insurer cancels the coverage under the Policy, the Insurer will mail or deliver the written notice to the Group at the last address stated in the Insurer's records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the <45th -91sl > day after the Insurer mails or delivers the written notice.

If the Group cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Insured Person's period of coverage. No benefit is payable for charges incurred after the effective date of cancellation of coverage under the Policy, except as provided in the Policy's benefit provisions.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Form 54.1201 ER VT Page 1

Cancellation of Insured Person's Coverage: An Insured Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.

Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly, semi-annually, annually, or for a specified term less than one year. Coverage will terminate if the required premium is not paid to the Insurer, subject to the Grace Period. Premium is charged from the date insurance for each Insured Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Premium Due Dates: The Insured Person's first premium is due and payable on the Insured Person's Effective Date of Coverage.

Change in Premium: The Insurer may change the premiums due on or after the first Policy Anniversary Date. The Insurer shall give written notice of such change at least 60 days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended. If the Insurer changes rates, the change will apply only to coverage starting on or after the effective date of the change. The Insurer will give the Policyholder at least 31 days advance written notice of any change.

INDIVIDUAL CERTIFICATES

The Insurer will furnish to the Policyholder, for delivery to each Eligible Participant, an individual certificate setting forth in substance the essential features of the insurance coverage of such Eligible Participants and to whom benefits thereunder are payable.

NEW MEMBERS

New Members: Eligible new employees and dependents may be added to the Group Policy, in accordance with the terms of the Policy and the attached Certificate.

GENERAL PROVISIONS

Entire Contract; **Changes**: This Policy, including the Certificate and any attached endorsements and papers, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses:

- (a) After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy, shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two year period.
- (b) No claim for loss incurred or disability (as defined in this Policy) commencing after two years from the effective date of coverage under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under this Policy.

Grace Period: There is a Grace Period of 31 days allowed for the payment of each premium after the first premium, during which Grace Period this Policy shall continue in force.

Reinstatement: If any renewal premium be not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any of Our agents duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy; provided, however, that if We or Our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten days after such date. In all other respects the Policyholder and We shall have the same rights hereunder as We both had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

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.

Form 54.1201 ER VT Page 2

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

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

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

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

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

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

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

Physical Examination 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.

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.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of 4 Ever Life Insurance Company.

HFBLackam, II

GROUP INSURANCE POLICY
PROVIDING ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable

Form 54.1201 ER VT Page 3

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: [c/o Authorized Administrator, Address 1, Address 2, City/State/Zip]

[Product Name]

[<\$0 - \$10,000> Deductible Plan]

Major Medical Plan

Certificate of Coverage Number: Effective Date:

This Plan is a Participating Provider Plan for major medical care.

Under this Plan, 4 Ever Life Insurance Company (Insurer) pays certain benefits at higher payment percentages when the services of a Participating Provider are used.

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit when it is in connection with a Medical Emergency.

The Insurance Coverage Area is any place that is {outside the United States / anywhere in the world}.

Table of Contents

HFBLackam, II

| I. | Introduction | Page 2 |
|-------|--|----------|
| II. | Who is eligible for coverage? | Page[7 |
| III. | Definitions | Page 11 |
| IV. | How the Plan Works | Page 21 |
| V. | Benefits: What the Plan Pays | Page 23 |
| VI. | Exclusions and Limitations: What the Plan does not pay for | Page 36 |
| VII. | Prescription Drug Benefits | Page 39 |
| VIII. | General Provisions | Page 42] |

I. Introduction

About This Plan

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

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

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

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

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

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 [Authorized Administrator Name] as its administrator.

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. [Authorized Administrator Name] provides a list to Eligible Participants of Foreign Country Providers with whom [Authorized Administrator Name] 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 [Authorized Administrator Name] is able to provide background information and to arrange access for Insured Persons.

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

[Authorized Administrator/4 Ever Life Insurance Company] has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services inside the United States, Puerto Rico, or the United States Virgin Islands, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between [Authorized Administrator/4 Ever Life Insurance Company] and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care inside the United States, Puerto Rico, and the United States Virgin Islands, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). In some instances, you may obtain care from providers that do not contract with the Host Blue (non-participating healthcare providers). [Authorized Administrator/4 Ever Life Insurance Company's] payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, [Authorized Administrator/4 Ever Life Insurance Company] will remain responsible for fulfilling [Authorized Administrator/4 Ever Life Insurance Company] contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to [Authorized Administrator/4 Ever Life Insurance Company].

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

discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price [Authorized Administrator/4 Ever Life Insurance Company] use[s] for your claim because they will not be applied retroactively to claims already paid.

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

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

1. Member Liability Calculation

When covered healthcare services are provided inside the United States, Puerto Rico, or the United States Virgin Islands by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment [Authorized Administrator/4 Ever Life Insurance Company] will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, [Authorized Administrator/4 Ever Life Insurance Company]may use other payment bases, such as billed covered charges, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount [we/Licensee Name] will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment [Authorized Administrator/4 Ever Life Insurance Company] will make for the covered services as set forth in this paragraph.]

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.

OVERVIEW MATRIX

| | Limits Outside the U.S. | [Limits In Network, U.S.] | [Limits Out-of-Network, U.S.] | | |
|--|--|--|--|--|--|
| MEDICAL EXPENSES | | | | | |
| Deductible Any deductible paid for one column will be applied towards the deductible in another column. | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | | |
| Payment Level One | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75 - 100%> of the Usual and Customary Fee.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75 - 100%> of the Negotiated Rate.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75-100%> of the Usual and Customary Fee.] | | |
| Payment Level Two | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | | |
| Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the deductible in another column. | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | | |
| [ACCIDENTAL DEATH AND DISMEMBERMENT | Maximum Benefit: Principal Sum up to <\$10,000 - \$100,000>] | | | | |
| [REPATRIATION OF REMAINS | Maximum Benefit up to <\$10,000 - \$50,000>] | | | | |
| [MEDICAL EVACUATION | Maximum Lifetime Benefit for all Evacuations up to <\$50,000 - \$1,000,000>] | | | | |
| [BEDSIDE VISIT | | 00 - \$10,000> for the cost of one econo ns in, the place of the Hospital Confine | | | |

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

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | | | | |
|---|--|--|---|--|--|--|--|
| Preventive Care Services – Deduct | Preventive Care Services – Deductible is not applicable | | | | | | |
| For Dependent Children (Birth to Age 19) | 100% of the Usual and Customary Fee | 100% of the Negotiated Rate | {All except a <\$0 - \$100> Copayment / (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| For Adults (Age 20 and Older) | 100% of the Usual and Customary Fee | 100% of the Negotiated Rate | {All except a <\$0 - \$100> Copayment / (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| Services Provided by a Physician of applicable] | or Provider – Copayments [[and Ded | uctible apply] if applicable unless sp | ecifically stated /Deductible is not | | | | |
| Physician Office Visits | [Deductible does not apply] [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [Deductible does not apply] [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [Deductible does not apply] [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| Surgical Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| Medical Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| Emergency Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| Other Physician services | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | | | | |
| [Annual Physical Examination/Health screening for services not covered by Preventative Care] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year.] | | | | |
| [Travel Vaccinations/Immunizations not covered under Preventative Care Services] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year.] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] | | | | |
| Services and Supplies Provided by | a Hospital – Copayments and Dedu | ctible apply if applicable, unless spe | cifically stated | | | | |
| Inpatient Hospital Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Outpatient Hospital Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | | | | |
|--|--|--|---|--|--|--|--|
| Emergency Care ¹ | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Other Services and Special Conditions - Copayments [[and Deductible apply] if applicable, unless specifically stated | | | | | | | |
| Ambulance Transportation | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Ambulatory Surgical Facility | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Autism Spectrum Disorders | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Dental Care for an Accidental Injury | Same as any Injury / <50% - 100% | %> of Covered Expenses up to <\$50 – [and limited to <\$50 – 200> per tooth | | | | | |
| Maternity | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Mental Illnesses | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Chiropractic Care | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year | [Deductible does not apply] {After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 - 50> visits per {Policy/Calendar} Year [| | | | |
| Physical/Occupational/Speech Therapy/Medicine and Other Specified Therapies | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | | | | |
| Infusion Therapy/Radiation Therapy/Chemotherapy | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| Human Organ Transplants | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | | | | |
| [Infertility Treatment | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime] | | | | |
| Home Health Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | | | | |
| Skilled Nursing Facilities | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | | | | |
| Hospice | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | | | | |

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | | | |
|---|--|--|------------------------|--|--|--|
| | here) | here) | here) | | | |
| Pharmacy Benefits | | | | | | |
| Pharmacy – Outside the US Maximum <30 – 180> day supply | {<50% - 100%> of actual charge / the Copayment stated below} | | | | | |
| Prescription Drugs | All except a <\$ | 5 - \$30> Copayment per prescription, p | er 30 day supply | | | |
| 2. Injectables | All except a <10 | % - 30% Copayment per Prescription, p | per 30 day supply] | | | |
| Pharmacy – Inside the US Maximum <30 – 180> day supply | {<50% - 100 | {<50% - 100%> of actual charge / the Copayment stated below} | | | | |
| Generic Drugs | All except a <\$ | 5 - \$30> Copayment per prescription, p | er 30 day supply | | | |
| 2. Brand name Drugs | All except a <\$ | 5 - \$30> Copayment per prescription, p | er 30 day supply | | | |
| 3. Injectables | All except a <10 | % - 30% Copayment per Prescription, p | oer 30 day supply] | | | |
| Hearing Services | No Deductible. <50% - 100%> of Covered Expenses per Policy Year up to a maximum of \$500 for Hearing Services that are not the result of an Injury or Illness. In addition, for a Covered Person who is a Dependent Child under age 24, 100% of Covered Expenses up to a maximum of \$1,000 per Hearing Aid every three years. | | | | | |
| [Vision Care | No Deductible. <50% - 100%> of Covered Expenses per Policy Year up to a maximum of <\$250 -\$1,000> for Vision Care that is not the result of an Injury or Illness.] | | | | | |
| [Dental Care | Subject to a maximum Covered Expenses of <\$500 - \$3,000> per {Policy/Calendar} Year. | | | | | |
| Preventive Dental Services | | 100% of Actual Cost | | | | |
| 2. Primary Dental Services | <100% - 50%> of Actual Cost | | | | | |
| Major Dental Services | <100% - 50%> of Actual Cost [Major Dental Services are not covered during the first <3 - 6> months the Insured Person is insured.] | | | | | |
| [Orthodontic Dental Care | No Deductible. 50% of Actual Cost up to a Lifetime Maximum of <\$500 - \$3,000> [Orthodontic expenses are not covered during the first <3 – 6> months the Insured Person is insured.] | | | | | |

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

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], [employee], 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 Employee

An Eligible Employee means a permanent full time employee or trainee, who usually works at least <20 – 40> hours a week in the conduct of the Group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis. [An Eligible Employee does not include an employee who works on a part-time, temporary, or substitute basis.] [An Eligible Employee may be a consultant or contractor engaged by the Group in the conduct of its business and works in the conduct of the Group's business at least <20 – 40> hours a week.] [An Eligible Employee also includes officers and directors of the Group regardless of the number of hours a week devoted to the conduct of the Group's business.] [An Eligible employee resides outside his/her Home Country and is scheduled to reside outside his/her Home Country for a period greater than <3 – 24> months.]

[If two members of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Group, then each must enroll separately as an Insured Participant.]

[Eligible Dependents

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

- 1. Spouse, or civil union partner, [or domestic partner]:
- 2. natural child, stepchild or legally adopted child and includes a dependent of a civil union [or domestic partnership] who has not yet reached age 26;
- 3. own or spouse's or civil union partner's or domestic partner'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 or spouse/partner. 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. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.]

[As used above:

- 1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
- 2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
- 3. The term "domestic partner" means a person of the same or opposite sex who:
 - a. is not married or legally separated;
 - b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
 - is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months:
 - d. occupies the same residence as the Eligible Participant;
 - e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
 - f. as entered into a domestic partnership arrangement with the named Insured.
- 4. The term "domestic partnership arrangement means the Eligible Participant and another person of the same or opposite sex has any three of the following in common:
 - a. joint lease, mortgage or deed;
 - b. joint ownership of a vehicle;
 - c. joint ownership of a checking account or credit account;
 - d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
 - e. designation of the domestic partner as a beneficiary of the employee's will;
 - f. designation of the domestic partner as holding power of attorney for health care; or
 - a. shared household expenses.
- 5. The term "civil union partner" means a person with whom the Eligible Participant has entered into a civil union in accordance with Vermont law.
- 6. The term "civil union" means that two eligible persons have established a relationship pursuant to Vermont Statute, Title 15, Chapter 23 and are thereby entitled to receive the benefits and protections and be subject to the responsibilities of spouses.]

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. [Citizen of the U.S. or permanent resident of the U.S. (as defined by the immigration code of the U.S.)]
- 2. [Employed by a company with offices in the U.S.]
- 3. [not a resident of the U.S.]
- 4. [his/her Home Country is not the U.S.]
- 5. [under Age <60 85>].
- 6. [Country of Assignment is other than the Eligible Participant's Home Country.]

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. [Applications will be accepted up to 30 days after the Initial Eligibility Date, however,] 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. <u>Newborn Children:</u> 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. <u>Court Ordered Coverage for a Dependent:</u> If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is a spouse or civil union partner [or domestic partner] 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. <u>Adopted Children:</u> 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.

[Special Enrollment Periods

- Eligible Participants who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they have other coverage may do so within 31 days after that other coverage terminates if the following requirements are met:
 - a. If the other coverage was COBRA continuation under another plan, that continuation must have been exhausted before the Eligible Participant may enroll the affected persons under this Plan.
 - b. If the other coverage was not COBRA continuation, then any employer contribution toward the cost of the coverage must have terminated or that coverage must itself have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:

- legal separation or divorce;
- ii. death:
- ii. termination of employment or reduction in hours of employment.

The Eligible Participant must have declined enrollment for employee and/or dependent coverage during the Initial Enrollment Period by means of a written statement that the reason for declining enrollment was other coverage.

- 2. An Eligible Participant who did not enroll during the Initial Enrollment Period may enroll for participant and/or dependent coverage within 31 days after he or she marries or acquires an Eligible Dependent Child or Children by birth, adoption, or placement for adoption.
- 3. An Eligible Participant who did not enroll his or her spouse or civil union partner [or domestic partner] during an Initial Enrollment Period may enroll that spouse or civil union partner [or domestic partner] within 31 days after the Eligible Participant acquires an Eligible Dependent Child or Children by birth or adoption or placement for adoption.

If an Eligible Participant does not apply within the 31 days of the Initial Enrollment Period or within the 31 days of a Special Enrollment Period as outlined above, he/she will become a Late Enrollee.]

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;
- 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 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:

- the date the Insured Participant's Insured Dependent no longer meets the definition of an Eligible Dependent as defined in the Planthe end of the
 period for which premium payment has been made to the Insurer;
- 2. the date the Policy terminates;
- 3. the date the Insured Participant's coverage terminates;
- 4. 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.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits" provisions of this Certificate or as specified below when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

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;
- on any premium due date for any of the following reasons. The Insurer must give the Group written notice of at least 30 days in advance if termination is due to:
 - a. failure to maintain the required minimum premium contribution;

- b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
- c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.
- 4. on any premium due date if the Insurer is also canceling all Group Health Benefit Plans in the state or in a geographic Service Area. The Insurer must give the Group written notice of cancellation:
 - a. at least 180 days in advance; and
 - b. again at least 30 days in advance.

Extension of Benefits

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

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

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

[Continuation (COBRA)

Most employers in the United States who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law, which governs this provision the Insured Participant may also be entitled to a period of continuation of coverage under this Act. The Insured Participant should check with his/her employer for details.]

III. Definitions

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

Accidental Injury means an accidental bodily Injury sustained by an Insured Person, which is the direct cause of a loss and which is not the result of disease or bodily infirmity.

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

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

Age means the Insured Person's attained age.

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

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

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

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

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

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Autism Services Provider means any licensed or certified person providing treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder and Asperger's disorder.

Diagnosis of Autism Spectrum Disorders means medically necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other testing to determine whether an individual has one or more Autism Spectrum Disorders. For purposes of this definition, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a licensed Physician or by Psychologist if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing.

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

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

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

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

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

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

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs. Includes medically-necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Chiropractor means a duly licensed chiropractor.

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

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider.

Claim Payment means the benefit payment calculated by the Insurer, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider.

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

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulates the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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 {Policy/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 or are caused by pregnancy, isuch as acute nephritis, nephrosis, cardiac decompression, missed abortion, 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 false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

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

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

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

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. Reconstructive Surgery is surgery to correct the appearance of abnormal

looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons**.

Country of Assignment means the country for which the Eligible Participant has a valid 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.

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

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

Covered Person means the Insured, and any Eligible Dependents.

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

Creditable Coverage means coverage you had under any of the following:

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

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

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

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

Dentist means a duly licensed dentist.

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

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

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

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

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

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

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

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

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

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

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

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

Emergency (See Emergency Medical Care)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Habilitative Care or Rehabilitative Care means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals the provider has identified.

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

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

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

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, or the local/national authority if outside the United States.

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 or the local/national authority if outside the United States.

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

An **Illness** is a sickness or disease of an Insured Person, which first manifests itself after the Insured Person's Effective Date and while coverage is in force.

Individual Coverage means coverage under this Certificate for yourself but not your spouse or civil union partner [or domestic partner].and/or eligible dependent children.

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

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

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

Initial Enrollment Period is the 31 day period during which an Eligible 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)

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

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

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

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Plan. Insured Participant is also referred to as 'you'.

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

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

Investigative Procedures (See Experimental/Investigational).

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

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

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

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

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

Medical care means:

- 1. The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
- 2. Transportation primarily for and essential to medical care referred to in Paragraph (1).

Medically Necessary (See exclusions section of this certificate)

Mental Health Care Professional means any person, corporation, facility or institution certified or licensed by this state to provide mental health care services, including but not limited to a physician, a nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such provider acting in the course and scope of employment or an agency related to mental health care services.

Mental Health Review Agent means a person or entity performing service review activities who is either affiliated with, under contract with, or acting on behalf of a business entity in the state of Vermont; or a third party who provides or administers mental health care benefits to citizens of Vermont, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care Physicians to coordinate delivery of services, authorized to offer health insurance policies or contracts in Vermont.

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient, or as approved by the Authorized Administrator. Mental Illness will also include Substance Abuse and the following biologically-based mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- schizophrenia;
- 2. bipolar disorder:
- obsessive-compulsive disorder;
- major depressive disorder;
- 5. panic disorder;
- 6. anorexia nervosa;
- 7. bulimia nervosa;
- 8. schizo-affective disorder; and
- 9. delusional disorder.

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

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

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

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

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

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

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

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

Nursing at Home Care Program means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on

an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Occupational Therapist means a duly licensed occupational therapist.

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

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

- 1. History (gathering of information on an Illness or Injury).
- Examination.
- 3. Medical Decision Making (the Physician's diagnosis and Plan of treatment).

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

Optometrist means a duly licensed optometrist.

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

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

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

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

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

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

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

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

Physical Therapist means a duly licensed physical therapist.

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

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits.

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits. Includes a licensed naturopathic physician working within the scope of his or license providing covered services or treatment.

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

Podiatrist means a duly licensed podiatrist.

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

Preexisting Condition means any condition for which medical advice or treatment was recommended by or received from a legally qualified physician within 6 months prior to the Coverage Date for the insured.

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

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

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

Psychologist means a Registered Clinical Psychologist.

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

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

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

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

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

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

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

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

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

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

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

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

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.

Speech Therapist means a duly licensed speech therapist.

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

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

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

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

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

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

Therapeutic Care means services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers for the Treatment of Autism Spectrum Disorders.

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

Treatment of Autism Spectrum Disorders means the following care prescribed, provided, or ordered for an individual diagnosed with one or more autism spectrum disorders by a licensed Physician or a licensed psychologist if such physician or psychologist determines the care to be medically necessary:

- 1. Habilitative Care or Rehabilitative Care;
- 2. pharmacy care;
- psychiatric care;
- 4. psychological care; and
- Therapeutic Care.

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

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

U.S. means the United States of America, including Puerto Rico and the US Virgin Islands.

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 {Policy/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/Calendar} Year. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received from either Participating or Non-Participating Providers each {Policy/Calendar} Year before any benefits are available. The Annual Deductible does not apply to those Office Visits for which a Copayment is required. Annual maximum Deductibles (if any) for the Insured Eligible Participant and his/her Eligible Dependents is stated in the Overview Matrix.

Coinsurance Maximums

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

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

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

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

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

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

Plan Payment

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

First Level Payment

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

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

Second Level Payment

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

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

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

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 the Overview Matrix and the Schedule of Benefits.

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. Whenever the term "you or your" is used, it is meant to mean all eligible Insured Person's as described in described under the Eligibility Section of this document.

Preventive Care Services

Benefits will be provided for preventive care services rendered to an Insured Person, even though they are not ill. Services described below received while outside the United States or inside the United States at an in-network provider will not be subject to a deductible, co-payment or co-insurance. Benefits will be limited to the following services:

Coverage for Preventative Items and Services

- Except as otherwise provided in Subsection 2 below, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved:
 - a. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
 - b. With respect to infants, children and adolescents, evidence-informed preventive care, and screenings, including hearing loss screenings, provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - c. With respect to women, to the extent not described in Subsection 1.a., evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- 2. The Insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection 1 after the recommendation or guideline is no longer described in Subsection 1.
 - a. The Insurer will give sixty (60) days advance notice to the Eligible Participant before any material modification to the services in Subsection 1 become effective.

Additional Benefits Provided: Benefits will be limited to the following services:

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes. Benefits will be provided if these services are prescribed by a health care professional legally authorized to prescribe such training and education under law and rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management.

Benefits for such health care professionals will be provided at the same benefit levels as those provided for any other covered condition.

Diabetes Equipment and Supplies

Benefits are also available for diabetes equipment and supplies prescribed by a health care professional legally authorized to prescribe such equipment and supplies under law for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes.

Benefits for such equipment and supplies will be provided at the same benefit levels as those provided for any other covered condition.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or Pap smear test for females aged 18 and older.

Mammograms

- 1. a baseline mammogram for asymptomatic women at least 35 years of age;
- 2. a mammogram every 1 to 2 years for asymptomatic women age 40 to 50, but no sooner than 2 years after a baseline mammogram;
- 3. a mammogram every year for asymptomatic women age 50 and over.

Benefits will also be provided for any woman when a Physician's evaluation of a woman's physical conditions, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

Prostate Test and Digital Rectal Examination Benefits will be provided for routine prostate-specific antigen tests and digital rectal examinations in accordance with American Cancer Society guidelines.

Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening for persons 50 years of age or older. Screening includes:

- An annual fecal occult blood tests (3 specimens).
- 2. A flexible sigmoidoscopy every 5 years.
- 3. A colonoscopy every 10 years.
- 4. A double contrast barium enema every 5 years.

In addition, benefits will be provided for people who are considered to be high risk for colon cancer because of:

- 1. Family history of familial adenomatous polyposis;
- 2. Family history of hereditary nonpolyposis colon cancer;
- 3. Chronic inflammatory bowel disease;
- 4. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- 5. A background, ethnicity or lifestyle is determined to be at elevated risk.

[Annual Physical Examination/Health Screening

An Annual Physical Examination or Health Screening for services not covered under the Preventive Care Services above included in the coverage according to the limits stated in the Schedule of Benefits.]

[Travel Vaccinations/Immunizations

Recommended travel vaccinations/immunizations not covered under the Preventative Care Services above are covered according to the limits stated in the Schedule of Benefits.]

Services Provided by a Physician

Surgery

Benefits are available for Surgery performed by a Physician or Dentist. However, for services performed by a Dentist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

- 1. [surgical removal of complete bony impacted teeth;]
- 2. excisions of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- 1. Anesthesia Services if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
- 2. Assistant Surgeon that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

Benefits for Surgery will be provided at the percent level shown in the Schedule of Benefits.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at the percentage of the Claim Charge as shown in the Schedule of Benefits. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

[After your Copayment,] Benefits for Additional Surgical Opinion will be provided at the percent level shown in the Schedule of Benefits.

Medical Care

Benefits are available for Medical Care visits when:

you are an Inpatient in a Hospital or Substance Abuse Treatment Facility; or

- 2. you are a patient in a Partial Hospitalization Treatment Program; or
- 3. you visit your Physician's office or your Physician comes to your home.
- 4. After any Copayment, Medical Care Benefits are provided at the percent shown in the Schedule of Benefits.

Other Physician Services

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the **Special Conditions & Payments** section of this Certificate.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Chemotherapy

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits for any Physician or Hospital charges associated with treatment. Your coverage includes benefits for Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits.

Radiation Therapy treatments

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits for any Physician or Hospital charges associated with treatment.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association or similar body. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits will be provided as shown in the Schedule of Benefits.

Other Specified Therapies

Benefits will be provided as shown in the Schedule of Benefits for other Specified Therapies, which include: Biofeedback, Chelation Therapy, Hearing Therapy, Orthoptics & Vision Therapy, Pulmonary and Respiratory Rehabilitation. Services must be rendered by a licensed Provider and must be prescribed to treat a covered illness or injury.

Diagnostic Service

Benefits will be provided for those services related to covered Surgery or Medical Care.

Benefit Payment for other Physician Services

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits when you receive any of the Covered Services described in this Physician Benefit Section from a Provider or from a Dentist.

Emergency Accident or Medical Care

Treatment must occur within 72 hours of the accident.

Benefit Payment for Emergency Accident or Medical Care

[After your Copayment,] Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits.

Services and Supplies Provided by a Hospital

Inpatient Care

The following are Covered Services when the Insured Person receives them as an Inpatient in a Hospital.

Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits when you receive Inpatient Covered Services. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Inpatient Covered Services

- 1. Bed, Board and General Nursing Care when you are in:
 - a. a semi-private room
 - b. a private room (at semi-private room rate)
 - c. an intensive care unit
- 2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Payment of Inpatient Covered Expenses are subject to these conditions:

- 1. Services must be those, which are regularly provided and billed by the Hospital.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.
- 3. No benefits will be provided for personal items, such as TV, radio, quest trays, etc.

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery that you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

[Parental Accommodation

Hospital charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12. Benefits are limited to a maximum of \$500 per inpatient admission.]

Extension of Benefits in Case of Termination

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate that are rendered by and regularly charged for by a Hospital. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

Outpatient Hospital Care

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

- 1. Surgery and any related Diagnostic Service received on the same day as the Surgery
- 2. Radiation therapy treatments
- 3. MRI
- Chemotherapy
- 5. Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
- 6. Diagnostic Service when you are an Outpatient and these services are related to surgery or Medical Care
- 7. Emergency Accident Care treatment must occur within seventy-two (72) hours of the accident
- 8. Emergency Medical Care

Outpatient Hospital Care Benefit Payment

[After you have met your Copayment,] Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits.

Benefit Payment for Hospital Emergency Care

After you have met your Copayment, benefits will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits when you receive Emergency Accident Care or Emergency Medical Care.

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

Other Covered Services and Special Conditions

Ambulance Transportation

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.

Non Covered Services for Ambulance include but are not limited to, trips to:

- 1. a Physician's office or clinic;
- 2. a morgue or funeral home.
- 3. for long distance trips or for use of an ambulance because it is more convenient than other transportation

Ambulatory Surgical Facility

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Ambulatory Surgical Facility for Outpatient Surgery will be provided as shown in the Schedule of Benefits.

[Autism Spectrum Disorders - Diagnosis and Treatment in Covered Children

Coverage is provided for the diagnosis and Treatment of Autism Spectrum Disorders and includes Applied Behavior Analysis supervised by a nationally board-certified behavior analyst and provided by a licensed Autism Services Provider for Covered Dependents beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

Benefits are payable on the same basis as any other sickness.

Services for Mental Illnesses

Both inpatient and outpatient coverage is provided for the diagnosis and treatment of Mental Illness. Benefits for Mental Illness services are the same as benefits for any other condition as specified in the Schedule of Benefits.

Cardiac Rehabilitation Services

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.

Chiropractor Services

Exams, testing or manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractor Services as specified in the Schedule of Benefits.

Cleft Lip and Cleft Palate

Coverage shall be provided for Inpatient or Outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.

Cancer Clinical Trials

Benefits will be provided for routine costs for Covered Persons who participate in approved cancer clinical trials conducted under the auspices of the following cancer care providers ('cancer care providers'):

- 1. Vermont Cancer Center at Fletcher Allen Health Care:
- 2. The Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center; and
- 3. any Hospital and its affiliated, qualified cancer care providers.

For participation in clinical trials located outside Vermont, coverage under this benefit will be provided only if the Covered Person provides notice to the health benefit plan prior to participation in the clinical trial, and:

- 1. no clinical trial is available at a Vermont or New Hampshire cancer care provider described above;
- the Covered Person has already completed a clinical trial at an approved cancer care provider listed above and that provider has determined that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available at that time under an approved cancer care provider listed above; or

- 3. a. The health plan has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available; and
 - b. the patient's cancer care provider determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available under an approved cancer care provider listed above.

If a Covered Person participates in a clinical trial administered by a cancer care provider that is not in the health benefit plan's provider network, the health plan may require that routine follow-up care be provided within the health benefit plan's network, unless the cancer care provider determines this would not be in the best interest of the Covered Person.

As used in this benefit, "health benefit plan" means the Policy or any other applicable health benefit plan offered by the Insurer.

Dental Care for an Accidental Injury

Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. No benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

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

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

Benefits are payable as stated in the Schedule of Benefits.

Durable medical equipment

Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose

Hormone Replacement Therapy

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

Human Organ Transplants

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

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

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

- 1. Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.
- Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant

Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

- 3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.
- 4. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
 - a. Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery
 - b. Transportation by air ambulance for the donor or the recipient
 - c. Travel time and related expenses required by a Provider
 - d. Drugs that are Investigational
 - e. The cost of acquisition of the organ and any costs incurred by the donor

[Infertility

Covered services related to the diagnosis of infertility shall be same as any other condition.

Covered Services related to the treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer will be provided as shown in the Schedule of Benefits.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- 1. you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and
- 2. you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Special Limitations for Infertility Services

Benefits will not be provided for the following:

- 1. Services rendered to a surrogate mother for purposes of childbirth
- 2. Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures that use a cryo-preserved substance
- 3. Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization or other such body as approved by the Authorized Administrator.]

Infusion Therapy

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

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

Covered Services for Infusion Therapy are as follows:

- 1. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
- 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, unless treatment is 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:

- 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.

Medical Foods and Modified Food Products

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products when diagnosed and determined to be Medically Necessary by the Insured Person's Physician, and administered under the direction of a Physician.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry screened in newborn babies.

"Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means an amino acid modified preparation that is intended to be used under direction of a Physician for the dietary treatment of an inherited metabolic disease.

Benefits are provided to the same extent as for any other Illness under the Policy.

Ovarian Cancer Monitoring

Coverage shall be provided for CA-125 monitoring of ovarian cancer subsequent to treatment. This does not apply to routine screenings.

Other Covered Service

- 1. Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture
- 2. Allergy shots and allergy surveys
- 3. Blood and blood components
- 4. Leg, back, arm and neck braces
- 5. Oxygen and its administration
- 6. Medical and surgical dressings, supplies, casts and splints
- 7. Lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with guidelines set forth by the Division of Public Health

Scalp hair prosthesis Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease. Benefits are payable for up to \$500 per {Policy/Calendar} Year.

Pregnancy and Maternity Care

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Maternity benefits are **not** available for any Insured Person other than the Insured Participant or the Insured Participant's insured spouse or civil union partner [or domestic partner].

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when our Authorized Administrator determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family

Prosthetic appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

- 1. they are required to replace all or part of an organ or tissue of the human body, or
- 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

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

Sterilization

The Insured Participant's Plan includes benefits for tubal ligation or vasectomy.

Treatment to Bones or Joints in the Face, Neck or Head<8 VSA s 4089g; this mandate covers TMJ and replaces the above provision.> Benefits will be provided for the diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage will be:

- 1. the same as that provided under the Policy for any other musculoskeletal disorder in the body; and
- 2. provided when prescribed or administered by a Physician or a Dentist.

This benefit does not require coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

[Home Health Care

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

Benefits are provided when the Insured Participant or Insured Dependents are confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. A visit is defined as four or fewer hours of services provided by one of the following providers:

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

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

[Hospice Services

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

The Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is 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.

Services and Supplies Provided by a Skilled Nursing Facility

Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

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

Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:

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

Note: No benefits will be provided for:

- 1. Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the number of days as indicated in the Schedule of Benefits.

Hearing Services

[Hearing Services include audiometric exams, hearing aid evaluation test, and limited benefits for hearing aids. See the Schedule of Benefits for maximums, which apply for Hearing Services.]

For Covered Persons who are Dependent Children under age 24, coverage provided for hearing aids up to the amount shown in the Schedule of Benefits.

[Vision Care

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

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

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

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

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

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

Covered Services

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

- 1. Vision Examination
- 2. Single Vision Lenses
- 3. Bifocal Single Lenses
- 4. Bifocal Double Lenses
- 5. Trifocal Lenses
- Lenticular Lenses

- Contact Lenses
- Frames

Special Limitations

Benefits will not be provided for the following:

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

Benefit Payment for Vision Care

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

[Dental Care

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

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

Any expenses incurred beyond the benefit maximum are your responsibility.

Preventative Dental Services

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

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

Primary Dental Services

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

- Fillings
- 2. Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section
- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Endodontics
- 5. Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- 6. Apicoectomies
- 7. Hemisection
- 8. Biopsies of Oral Tissue
- 9. Periodontics/Periodontal Therapy; Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
- 10. Periodontal examination Benefits for periodontal examinations are limited to two per Benefit Period
- 11. Periodontal maintenance procedures Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
- 12. Stainless Steel Crowns
- 13. Repair of Removable Dentures
- 14. Recementing of Crowns, Inlays, Onlays and Bridges
- 15. General Anesthesia/Intravenous Sedation If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation

16. Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

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

Major Dental Services

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

- 1. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- 2. Fixed Bridgework
- 3. Bridge Repairs
- 4. Full and Partial Dentures
- 5. Denture Adjustments, Rebasing and Relining During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

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

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

[Orthodontic Dental Care

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

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

[Up to the age of 19,]Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. The limitations are as follows:

- 1. Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist;
- 2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment

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

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

Special Limitations

No benefits will be provided under this Benefit Section for:

- 1. Dental services which are performed for cosmetic purposes.
- 2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
- 3. Oral Surgery for the following procedures:
 - a. surgical services related to a congenital malformation;
 - b. surgical removal of complete bony impacted teeth;
 - c. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
- 4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
- 5. Hospital and ancillary charges are not covered.
- 5. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
- Any services, treatments or supplies included as an eligible benefit under other group hospital, dental, medical and/or surgical coverage.]

[Accidental Death and Dismemberment Benefit

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

Loss Benefit

Loss of life 100% of the Principal Sum

Loss of one hand50% of the Principal SumLoss of one foot50% of the Principal SumLoss of sight in one eye50% 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.]

[Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Insured Persons in any one Accident or disaster shall not exceed the sum of <\$300,000 - \$500,000>. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed <\$300,000 - \$500,000> the amount of indemnity payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed <\$300,000 - \$500,000>.]

[Repatriation of Remains Benefit

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

If you have minor children who are left unattended as a result of your injury, illness or medical evacuation, our Authorized Administrator will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to your Home Country or Country of Assignment.

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

[Bedside Visit Benefit

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than <3 – 7> days, is likely to be hospitalized for more than <3 – 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 <3 – 7> days or is in critical condition shall be made by the Authorized 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 Authorized 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

1. The following services and supplies are not covered:

Hospitalization, services and supplies that are not Medically Necessary.

No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately
 in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the
 convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Authorized Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Insurer will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Insurer, either at law or in equity. To initiate your appeal, you must give Insurer written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

Remember, even if your Physician prescribes, orders, recommends, approves or views hospitalization or other health care services and supplies as Medically Necessary, the Insurer will not pay for the hospitalization, services and supplies if its authorized administrator decides they were not Medically Necessary

- 2. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are provided under any Workers' Compensation Law or other similar laws. [This exclusion does not apply to Protection and Indemnity Insurance for Marine crew members.]
- 3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided by a local, state or federal government.
- 4. Services and supplies for any illness or injury occurring on or after your Coverage date as a result of war or act of war (whether declared or

- undeclared), participation in a felony, riot or insurrection.
- Custodial Care Service.
- 6. Routine physical examinations, unless otherwise specified in this Certificate.
- 7. Cosmetic Surgery and related services and supplies, except reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- 8. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- 9. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- 10. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- 11. [Foot care, except for persons diagnosed with diabetes, in connection with corns, calluses, flat fee, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.]
- 12. [Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.]
- 13. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- 14. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- 15. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- 16. Consultations performed by you, your spouse, parents or children.
- 17. [Treatment for hair loss.]
- 18. [Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).]
- 19. [Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.]
- 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. [Contact lenses and glasses unless otherwise specified in this Certificate.]
- 22. [Services and treatment related to elective abortions.]
- 23. [Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate.]
- 24. [Elective Abortions]
- 25. [Dental services unless elected by your Group.]
- 26. [Vision care services unless elected by your Group]
- 27. [Loss arising from [ultra light aircraft], [parasailing], [sail planning], [hang gliding].]

[Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to pregnancy, congenital anomalies of a covered dependent, a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, or Insured Dependents under age 19.

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

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

VII. Prescription Drug Benefits

Introduction and Definitions

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

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

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

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

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

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

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. Call the Insured Person's local Pharmacy or call the toll-free Prescription Benefit Customer Service phone number (x-xxx-xxx-xxxx) for a list of Participating Pharmacies in the Insured Person's area.

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

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

Prescription drugs purchased in Canada, and used in Canada or re-imported legally or purchased through the I-SaveRx program, will be covered on the same benefit terms and conditions as prescription drugs purchased in the U.S.

Conditions of Service

The Drug or medicine must be:

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

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

The Prescription must not exceed a <30 – 180> -day supply.

Reimbursement

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

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

When the Insured Person Goes to a Participating Pharmacy

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

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 3. For injectable, the Insured Person pays as stated in the Schedule of Benefits.

When the Insured Person Goes to a Non-Participating Pharmacy

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

When the Insured Person has his/her Prescription filled at a Non-Participating Pharmacy he/she will be reimbursed at the following rate for each covered Prescription and/or refill after the Insured Person's deductible is satisfied:

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

Claims and Customer Service

Drug claim forms are available at Participating Pharmacies or upon written request to Insurer.

If the Insured Person has any questions about his Prescription Drug Benefit, call the toll-free customer service number: [x-xxx-xxxx.]

Prescription Drug Exclusions and Limitations

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

- 1. Drugs and medications not requiring a Prescription, except insulin.
- 2. Self-administered injectable drugs, except insulin.
- 3. Non-medical substances or items.
- [[Contraceptive Drugs and [certain]] devices prescribed for birth control,] [Drugs and medications used to induce non-spontaneous abortions.]]
- 5. Dietary supplements, cosmetics, health or beauty aids.
- 6. Any vitamin, mineral, herb or botanical product, which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
- 7. Drugs taken while the Eligible Participant are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
- 8. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
- 9. Syringes and/or needles, except those dispensed for use with insulin.
- 10. Durable medical equipment, devices, appliances and supplies.
- 11. Immunizing agents, biological sera, blood, blood products or blood plasma.
- 12. Oxygen.
- 13. Professional charges in connection with administering, injecting or dispensing of Drugs.
- 14. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
- 15. Drugs used for cosmetic purposes.
- 16. Drugs used for sexual stimulation.
- 17. Drugs used for treating hair loss.
- 18. [Drugs used for the primary purpose of treating infertility.]
- 19. Anorexiants or Drugs associated with weight loss.
- 20. Allergy desensitization products, allergy serum.
- 21. All Infusion Therapy is excluded under this Plan except as specifically stated in the Covered Services section.
- 22. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Preexisting Condition, or other contract limitation.
- 23. Growth Hormone Treatment.
- 24. Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
- 25. [The replacement of lost or stolen Prescription Drugs.]
- 26. [Antihistamines.]

VIII. General Provisions

Entire Contract; Changes

The Policy, including this Certificate and any attached endorsements and papers, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of coverage under the Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the Policy.

Grace Period

There is a Grace Period of 31 days allowed for the payment of each premium after the first premium, during which Grace Period coverage under the Policy shall continue in force.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

Third Party Liability

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

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

Coordination of Benefits (COB)

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 Policy Year, and are largely determined by 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.
- 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.

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.

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.

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

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

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

The Claims Process

Notice of Claim: Within 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.

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

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

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

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

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

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

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

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:

- 1. It is duly executed on a form acceptable to the Insurer; and
- 2. A copy is on file with the Insurer.

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

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

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

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

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

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

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

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

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

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

The Insurer's right to examine any records that exist:

- During the time the Plan is in force; or
- Until the Insurer pay the last claim.

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

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

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

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

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services.

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS.

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

Review and determination of mental health claims may only be made by a licensed Mental Health Review Agent with the concurrence of a Mental Health Care Professional whose training and expertise is at least comparable to that of the treating clinician.

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:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

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.

Appeal Process

Expedited Claim Appeal

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

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

First Level Appeal

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

[Authorized Administrator]
[Address]
[City, State, zip code]
[Telephone number: xxx-xxx-xxxx]

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

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

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

Second Level Appeal

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

[Authorized Administrator]
[Address]
[City, State, zip code]
[Telephone number: xxx-xxx-xxxx]

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

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

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

Independent External Review

When a Covered Person has exhausted all applicable internal review procedures provided by the Insurer, such Covered Person will have the right to an independent external review of any decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review will be available when requested in writing by the affected insured, provided the decision to be reviewed requires the Insurer to expend at least \$100.00 for the service and the decision by the plan is based on one of the following reasons:

- 1. The health care service is a covered benefit that the health insurer has determined to be not medically necessary.
- 2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and rules.
- 3. The health care treatment has been determined to be experimental, investigational or an off-label drug. A health benefit plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal, and shall decide such appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the commissioner.
- 4. The health care service involves a medically-based decision that a condition is preexisting.

The right to an independent review will not be construed to change the terms of coverage under the Policy.

The independent external reviews will be conducted:

1. By independent review organizations pursuant to a contract with the department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section; and

2. In accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

The Covered Person will:

- 1. be provided with adequate notice of their review rights under this section;
- 2. have the right to use outside assistance during the review process and to submit evidence relating to the health care service;
- 3. pay an application fee of \$25.00 for each request for an independent external review of an appealable decision not to exceed a total of \$75.00 annually. The application fee may be waived or reduced based on a determination by the Commissioner of Insurance that the financial circumstances of the Covered Person warrants a waiver or reduction. The application fee will be paid by the Insurer, not the Covered Person, if the independent review organization reverses the Insurer's decision to deny payment for a health care service; and
- 4. Be protected from retaliation for exercising their right to an independent external review.

Other costs of the independent review will be paid by the Insurer.

The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan.

The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable state or federal laws.

The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure in accordance with Vermont law.

Decisions relating to the following health care services shall not be reviewed under this section, but shall be reviewed by the review process provided by law:

- 1. Health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan.
- 2. Health care services provided to inmates by the Department of Corrections.

4 Ever Life Insurance Company

Group Program EMPLOYER GROUP APPLICATION

Administered by:

[Authorized Administrator] [Address 1, Address 2] [City, State, Zip]

| Employer Informati | on | | | | |
|-----------------------------|----------------------------------|--------|----------------|------------------|--|
| Legal Company Name: | | | | Phone #: | |
| Address: | | | | | |
| Address: | | | | Fax #: | |
| City: | | State: | Zip: | | |
| Contact Name: | | | | Contact Phone #: | |
| Contact Email: | | | | | |
| Total | Number of Current Employees: | | | | |
| Number of E | mployees Eligible for this Plan: | | | | |
| Number o | of Employees with Dependents: | | | | |
| Employ | ver's Requested Effective Date: | | | | |
| We elect to offer the follo | wing coverages to our Employees: | | [Product Name] | ☐ Other | |
| | If Other, please describe: | | | | |

The Employer acknowledges that it is establishing this group insurance plan. [Neither 4 Ever Life Insurance Company nor the policyholder/trustee is acting as a "sponsor", as defined in ERISA. Employer agrees that any compliance with ERISA that is applicable to the Employer is the responsibility of such Employer.]

[Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not an eligible employee, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.]

The insurance coverage requested and requested effective date must be approved by [Authorized Administrator] under its current rules and practices, including Pre-Existing Condition provisions. All materials describing this coverage must be approved in writing by [Authorized Administrator] prior to distribution. Note: Premium rates quoted were based on the data submitted to [Authorized Administrator]. Final premium rates may be determined on the basis of the actual composition of the group of persons who become insured. I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for [Authorized Administrator] approval of the coverage requested.

Applicant hereby accepts the above quote and requests coverage designated by [Authorized Administrator] and appoints [Authorized Administrator] as its representative for the placement of this health insurance product.

Continued on page 2

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Form 54.1101 ER

FRAUD NOTICES

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

| Signed by the Employer: | | |
|---|------|-------|
| Date:/ | Name | Title |
| 4 Ever Life Insurance Company Representative: _ | | |
| Date:/ | Name | Title |

Please mail completed Group Application and accompanying Enrollment Forms if applicable to:

4 Ever Life Insurance Company c/o [Authorized Administrator, Address 1, Address 2, City/State/Zip Code] Questions Call: 1-xxx-xxxx

Form 54.1101 ER 2

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200, Oakbrook Terrace, Illinois 60181 • (800) 621-9215

MAJOR MEDICAL EXPENSE COVERAGE OUTLINE OF COVERAGE

- (1) Read Your Certificate of Coverage Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE OF COVERTAGE CAREFULLY!
- (2) Major Medical Expense Coverage Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to any deductibles, co-payment provisions or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.
- (3) Benefits The benefits outlined in the following tables show the payment percentages for Covered Expenses AFTER the Eligible Participant has satisfied any Deductibles and prior to satisfaction of his/her Coinsurance Maximum.

OVERVIEW MATRIX

| | Limits Outside the U.S. | [Limits In Network, U.S.] | [Limits Out-of-Network, U.S.] | |
|--|---|---|---|--|
| MEDICAL EXPENSES | | | | |
| Deductible Any deductible paid for one column will be applied towards the deductible in another column. | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | |
| Payment Level One | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75-100%> of the Usual and Customary Fee.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75-100%> of the Usual and Customary Fee.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75-100%> of the Usual and Customary Fee.] | |
| Payment Level Two | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | |
| Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the deductible in another column. | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$100,000> per Family per {Policy/Calendar} Year | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$100,000> per Family per {Policy/Calendar} Year | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$100,000> per Family per {Policy/Calendar} Year | |
| [ACCIDENTAL DEATH AND DISMEMBERMENT | Maximum Benefit: Principal Sum up to <\$10,000 - \$100,000>] | | | |
| [REPATRIATION OF REMAINS | Max | imum Benefit up to <\$10,000 - \$50,0 | 00>] | |
| [MEDICAL EVACUATION | Maximum Lifetime E | Benefit for all Evacuations up to <\$50 | 0,000 - \$1,000,000>] | |
| [BEDSIDE VISIT | Up to a maximum benefit of <\$1,000 - \$10,000> 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 the above Overview Matrix)

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] |
|---|---|--|---|
| Preventive Care Services – Deduc | ctible is not applicable | | |
| For Dependent Children (Birth to Age 19) | 100% of the actual charges | 100% of the Negotiated Rate | {All except a <\$0 - \$100> Copayment / (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| For Adults (Age 20 and Older) | 100% of the actual charges | 100% of the Negotiated Rate | {All except a <\$0 - \$100> Copayment / (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Services Provided by a Physician | or Provider – Copayments [[and De | eductible apply] if applicable/Deduc | tible is not applicable] |
| Surgical Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Medical Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Emergency Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Physician Office Visits | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Other Physician services | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| [Annual Physical Examination/Health screening for services not covered by Preventative Care] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year.] |
| [Travel Vaccinations/Immunizations not covered under Preventative Care Services] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year.] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] |
| Services and Supplies Provided b | y a Hospital – Copayments and Dec | ductible apply if applicable | |
| Inpatient Hospital Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Vaccinations/Immunizations not covered under Preventative Care Services] Services and Supplies Provided by | [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year.] by a Hospital – Copayments and Der (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] ductible apply if applicable (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Pa 1][and Payment Lev here)][up to a Maxim \$500> per {Policy/Ca (Overview Matrix, [Pa 1][and Payment Lev |

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] |
|---|--|--|---|
| Outpatient Hospital Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Emergency Care ¹ | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Other Services and Special Cond | itions - Copayments [[and Deductib | ole apply] if applicable/Deductible is | not applicable] |
| Ambulance Transportation | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Ambulatory Surgical Facility | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| [Autism Spectrum Disorders | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1[and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)] |
| Dental Care for an Accidental Injury | Same as any Injury / <50% - 100%> of Covered Expenses up to <\$50 – \$1,000> per Calendar Year maximum [and limited to <\$50 – 200> per tooth] | | |
| Maternity | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Mental Illnesses | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Chiropractic Care | [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 - 50> visits per {Policy/Calendar} Year | [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year | [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year [|
| Physical/Occupational Therapy/Medicine | [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. |
| Human Organ Transplants | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| [Infertility Treatment | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime |
| [Home Health Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] |
| Skilled Nursing Facilities | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] |
| [Hospice | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |

3

Form 54.1217 VT

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | | | |
|--|--|--|-------------------------------------|--|--|--|
| Pharmacy Benefits | | | | | | |
| [Pharmacy – Outside the US Maximum <30 – 180> day supply | {100%> c | {100%> of actual charge / the Copayment stated below} | | | | |
| Prescription Drugs | All except a <\$5 | - \$30> Copayment per prescription, p | per 30 day supply | | | |
| 2. Injectables | All except a <10% | 6 - 30% Copayment per Prescription, | per 30 day supply] | | | |
| [Pharmacy – Inside the US Maximum <30 – 180> day supply | {<50% - 100% | {<50% - 100%> of actual charge / the Copayment stated below} | | | | |
| Generic Drugs | All except a <\$5 | - \$30> Copayment per prescription, p | per 30 day supply | | | |
| 2. Brand name Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | | | |
| 3. Injectables | All except a <10% - 30% Copayment per Prescription, per 30 day supply] | | | | | |
| Hearing Services | No Deductible. <50% - 100%> of Covered Expenses per {Policy/Calendar} Year up to a maximum of <\$250 - \$1,000> for Hearing Services that are not the result of an Injury or Illness. In addition, for a Covered Person who is a Dependent Child under age 24. No Deductible. <50% - 100%> of Covered Expenses up to a maximum of \$1,000 per Hearing Aid every three years. | | | | | |
| [Vision Care | No Deductible. <50% - 100%> of Co \$1,000> for Vision Care that is not th | vered Expenses per {Policy/Calenda e result of an Injury or Illness.] | r} Year up to a maximum of <\$250 - | | | |
| [Dental Care | Subject to a maximum Covered Exp | penses of <\$500 - \$3,000> per {Police | cy/Calendar} Year. | | | |
| 1. Preventive Dental Services | | 100% of Actual Cost | | | | |
| 2. Primary Dental Services | | <100% - 50%> of Actual Cost | | | | |
| 3. Major Dental Services | [Major Dental Services are not of | <100% - 50%> of Actual Cost [Major Dental Services are not covered during the first <3 - 6> months the Insured Person is insured.] | | | | |
| [Orthodontic Dental Care | | of Actual Cost up to a Lifetime Maxi overed during the first <3 – 6> month | | | | |

- If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.
- (4) Exclusions and Limitations What the Plan does not pay for

Excluded Services

- <1.> The following services and supplies are not covered:
 - Hospitalization, services and supplies that are not Medically Necessary.
 - No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.
 - Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests)
 which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's
 office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service,

- convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Authorized Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Insurer will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Insurer, either at law or in equity. To initiate your appeal, you must give Insurer written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

BCS Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

Remember, even if your Physician prescribes, orders, recommends, approves or views hospitalization or other health care services and supplies as Medically Necessary, the Insurer will not pay for the hospitalization, services and supplies if its authorized administrator decides they were not Medically Necessary

- <2.> Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are provided under any Workers' Compensation Law or other similar laws. [This exclusion does not apply to Protection and Indemnity Insurance for Marine crew members.]
- <3.> Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided by a local, state or federal government.
- <4.> Services and supplies for any illness or injury occurring on or after your Coverage date as a result of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection.
- <5.> Custodial Care Service.
- <6.> Routine physical examinations, unless otherwise specified in this Certificate.
- <7.> Cosmetic Surgery and related services and supplies, except reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- <8.> Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- <9.> Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- <10.> Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- <11.> [Foot care, except for persons diagnosed with diabetes, in connection with corns, calluses, flat fee, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.]
- <12.> [Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.]
- <13.> Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- <14.> Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- <15.> Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

- <16.> Consultations performed by you, your spouse, parents or children.
- <17.> [Treatment for hair loss.]
- <18.> [Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).]
- <19.> [Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.]
- <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.> [Contact lenses and glasses unless otherwise specified in this Certificate.]
- <22.> [Services and treatment related to elective abortions.]
- <23.> [Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate.]
- <24.> [Elective Abortions]
- <25.> [Dental services unless elected by your Group.]
- <26.> [Vision care services unless elected by your Group]
- <27.> [Loss arising from [ultra light aircraft], [parasailing], [sail planning], [hang gliding].]

[Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to pregnancy, congenital anomalies of a covered dependent, a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, or Insured Dependents under age 19.

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.]

(5) Renewability, Continuation of Coverage under the Group Policy.

You may remain covered under the group policy until the occurrence of one of the following events:

- 1. the last day of the month after the date you no longer meets the definition of an Eligible Participant;
- 2. the end of the last period for which premium payment has been made to us;
- 3. the date you leave the country of assignment for your home country;
- 4. the date the group policy terminates;
- the date of fraud or misrepresentation of a material fact by you, subject to the Time Limit on Certain Defenses provision.

[Your insured dependents may remain covered under the group policy until the occurrence of one of the following events:

- 1. the date your 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 us;
- 3. the date the group policy terminates;
- 4. the date your coverage terminates;
- 5. the date of fraud or misrepresentation of material fact by the insured dependent, subject to the Time Limit on Certain Defenses provision.]

Extension of Benefits – If you are totally disabled on the date of termination of the group policy, coverage will be extended. Benefits will continue to be paid under the terms of the group 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 you cease 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 group policy is replaced by another carrier providing substantially equivalent or greater benefits.

Continuation (COBRA) – Most employers in the United States who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law that governs this provision you may also be entitled to a period of continuation of coverage under this Act. You should check with your employer for details.

SERFF Tracking #: BCSF-127963460 State Tracking #: 58065 Company Tracking #: MET 54.1201 VT

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Supporting Document Schedules

| Satisfied - Item: | Filing Compliance Certification |
|-------------------|---|
| Comments: | |
| Attachment(s): | VT Certificate of Compliance (signed 20120405).pdf |
| Item Status: | |
| Status Date: | |
| Satisfied - Item: | Flesch Score Certification |
| Comments: | |
| Attachment(s): | VT Certification of Compliance - Readability.pdf |
| Item Status: | |
| Status Date: | |
| Satisfied - Item: | Health Administrative Forms |
| Comments: | |
| Attachment(s): | VT F106 Filing Form.pdf |
| Item Status: | |
| Status Date: | |
| Satisfied - Item: | Health Filing Data |
| Comments: | Civil Union requirements have been incorporated into the forms. |
| Attachment(s): | Form 54.1201 ER VT (20120404 SOV).pdf Form Number 54.1301 ER VT (20120404 SOV).pdf |
| Item Status: | |
| Status Date: | |
| Satisfied - Item: | Redlined Copy |
| Comments: | |
| Attachment(s): | Form 54.1201 ER VT - Policy (20120404 redline).pdf Form Number 54.1301 ER VT - Cert (20120404 redline).pdf |
| Item Status: | |
| Status Date: | |
| Satisfied - Item: | Third Party Filing Authorization |
| Comments: | |
| Attachment(s): | authorization to file.pdf |

| SERFF Tracking #: | BCSF-127963460 | State Tracking #: | 58065 | | Company Tracking #: | MET 54.1201 VT | |
|----------------------|-----------------|-----------------------------|-----------------|-----------------|---------------------|----------------|--|
| State: | Vermont | | | Filing Company: | 4 Ever Life Insurai | nce Company | |
| TOI/Sub-TOI: | H16G Group Hea | alth - Major Medical/H16G.0 | 002C Large Grou | o Only - Other | | | |
| Product Name: | Group Major Med | dical | | | | | |
| Project Name/Number: | MET Group Majo | r Medical - Outbound/MET | 54.1201 VT F | | | | |
| Item Status: | | | | | | | |
| Status Date: | | | | | | | |
| Satisfied - Item: | D | PACA Uniform Compl | liance Summa | ir./ | | | |
| Comments: | | TACA CHIICHII COMPI | nance Summe | пу | | | |
| Attachment(s): | Р | PACA checklist.pdf | | | | | |
| Item Status: | | | | | | | |
| Status Date: | | | | | | | |
| | | | | | | | |
| Satisfied - Item: | R | esponses to 2012021 | 3 VT Objection | ns | | | |
| Comments: | | | | | | | |
| Attachment(s): | R | esponses to 2012021 | 3 VT Objection | ns.pdf | | | |
| Item Status: | | | | | | | |

Status Date:

4 Ever Life Insurance Company

Oakbrook Terrace, IL 60181

Certification of Compliance

RE: Group Major Medical Policy Form 54.1201 ER VT, et al.

- I, Linda Hickok, Vice President, certify to the best of my knowledge and belief that the attached forms comply with Vermont law, specifically the accident and health requirements of Regulation 80-1, and that:
- (1) only large employer-employee groups meeting the standards of 8 VSA § 4079(1) will be allowed to purchase this product; and
- (2) the forms will be issued only to large employer-employee groups meeting the standards of 8 VSA § 4079(1).

I further certify to the best of my knowledge and belief that the attached forms comply with:

- (1) Regulation H-2009-03 (NILS designation H-09-3), the Consumer Protection and Quality Requirements for Managed Care Organizations;
- (2) Regulation H-2008-01 (NILS designation H-08-1), the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES); and
- (3) the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA).

| Signature: | Lunda H. Ybihoh | |
|------------|-----------------|-----------------|
| | | |
| Date: | 4-5-12 | |

VERMONT CERTIFICATION OF COMPLIANCE FOR READABILITY

| Form number(s) | Form Name | Flesch Readability Score |
|----------------------------------|------------------------------------|--|
| Form 54.1201 ER VT | Group Policy | 45.2 |
| 1 01111 34.1201 LIX VI | Group Folicy | 40.2 |
| Form Number 54.1301 ER VT | Certificate of Coverage | 49.1 |
| Form 54.1217 VT | Outline of Coverage | 57.0 |
| Score is accurate, based on the | • • | ne Flesch Scale Analysis Readability ate the scores. I further certify that and standards of your State. |
| Signature: | N. Hickok | |
| Type the Name and Title: Linda I | H. Hickok, Assistant Vice Presider | nt, Compliance |
| Date: January 5, 2 | 2012 | |

Health Filing Form F106 (03/08) Required Information for All Filings & the Fee

| NAIC # | | 68 | 8039 | | |
|---|--|--|--|----------------------------------|---------|
| Company Name: | 4 Ever Life Insurance Company | | | | |
| Address: | 2 Mid America Plaza, Suite 200 | | | | |
| City, State, Zip: | Oakbrook Terrace, IL 60181 | | | | |
| Phone: <u>(609)</u> 443- | 7540 Contact Person | | Coulter & Asso | | 8512 |
| Filing Contents | | | | | |
| 2) □ Rates3) ☑ Policy□ Handbook | □ Contract | ☑ Rates & Fo ☐ Amendmen ☐ Certificate | orms t □ Endo □ Othe | orsement r: | |
| Type of Filing: | | | | | |
| □ Accident Only □ AD&D □ Advertising □ Blanket □ Cancer Expense □ Comprehensive ☑ Major Medical □ Conversion □ Critical Illness | ☐ Dental ☐ Disability ☐ Home Health ☐ Hospital Inde ☐ Limited Bender Long Term Cate ☐ Qualite ☐ Non- ☐ Medicare Su | emnity: efit: re: fied Qualified | ☐ Miscellaneon ☐ Nursing Hor ☐ Organ Trans ☐ Prescription Student/Athlet ☐ Stop Loss/Ex ☐ Travel ☐ Vision ☐ Other: | ne Only plant Drug e: □ | |
| Mandatory – Filing | Fee Information | | | | |
| 4. Explain how each | | ermined, show | • | | neet if |
| 5. Fee Calculated b | y: Frank Cripps, Consu (Printed Name) | ıltant | (Sign | ature) | |

GENERAL STATEMENTS: In no event will variables be less favorable to an insured than the minimum standards set forth in Vermont law.

Blue-faced type is either editing/issuing notations or comments meant to explain how the variable material is to be handled. **Red-faced** type is either illustrative "John Doe" information or the actual variables that will be made available. Numeric variables are shown in **Green** and range from minimum to maximum.

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

[Product Name] MAJOR MEDICAL EXPENSE INSURANCE

POLICYHOLDER: Employer ← Actual policyholder/employer's name shown here.

POLICY EFFECTIVE DATE: Month, Date, Year ← Actual policy effective date shown here.

POLICY NUMBER: ### ("the Policy")← Actual policy number shown here.

STATE OF DELIVERY: Vermont

ADMINISTRATOR: ABC Administrator ← Name and address of plan administrator shown here.

This Policy is a legal contract between the Policyholder and BCS Insurance Company (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGREEMENT

This Policy, the Certificates issued under the policy, the application(s) of the Group form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by an Insured Person, by the Insurer's Agent, or by any other person are not part of this Policy. Only the Insurer's President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Insured Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date and

POLICY TERM

Policy Effective Date: <MM/DD/YYYY ← Policy effective date shown here.

Policy End Date: <MM/DD/YYYY> ← First renewal date shown here.

Policy Termination Date: The Policy will continue in force for the while the required premiums are paid until the Policy End Date or the Policy is terminated by either the Policyholder or by the Insurer. At least 31 – 90 days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Group's coverage under the Policy may be canceled at any time after 31 – 90 days written notice mailed or delivered by the Insurer to the Group or by the Group to the Insurer.

If the Insurer cancels the coverage under the Policy, the Insurer will mail or deliver the written notice to the Group at the last address stated in the Insurer's records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the 32nd – 91st day after the Insurer mails or delivers the written notice.

If the Group cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Insured Person's period of coverage. No benefit is payable for charges incurred after the effective date of cancellation of coverage under the Policy, except as provided in the Policy's benefit provisions.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Cancellation of Insured Person's Coverage: An Insured Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.

Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator.

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly, semi-annually, annually, or for a specified term less than one year. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Insured Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Premium Due Dates: The Insured Person's first premium is due and payable on the Insured Person's Effective Date of Coverage.

Change in Premium: The Insurer may change the premiums due on or after the first Policy Anniversary Date but not more often than once in any 12 month period ← Term may vary based upon the plan specifications. The Insurer shall give written notice of such change at least 31 – 90 days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended. If the Insurer changes rates, the change will apply only to coverage starting on or after the effective date of the change. The Insurer will give the Group at least 31 days advance written notice of any change.

INDIVIDUAL CERTIFICATES

The Insurer will furnish to the Group', for delivery to each Eligible Participant, an individual certificate setting forth in substance the essential features of the insurance coverage of such Eligible Participants and to whom benefits thereunder are payable.

NEW MEMBERS

New Members: Eligible new employees and dependents may be added to the Group Policy, in accordance with the terms of the Policy and the attached Certificate.

GENERAL PROVISIONS

Entire Contract; **Changes**: This Policy, including the Certificate and any attached endorsements and papers, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses:

- (a) After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy, shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two year period.
- (b) No claim for loss incurred or disability (as defined in this Policy) commencing after two years from the effective date of coverage under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under this Policy.

Grace Period: There is a Grace Period of 31 days allowed for the payment of each premium after the first premium, during which Grace Period this

Policy shall continue in force.

Reinstatement: If any renewal premium be not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any of Our agents duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy; provided, however, that if We or Our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten days after such date. In all other respects the Policyholder and We shall have the same rights hereunder as We both had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

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.

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

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

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

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

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

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

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

Physical Examination 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.

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.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and

the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of BCS Insurance Company.

GROUP INSURANCE POLICY
PROVIDING ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable

HFBLULLAM, II

GENERAL STATEMENTS: In no event will variables be less favorable to an insured than the minimum standards set forth in Vermont law.

Blue-faced type is either editing/issuing notations or comments meant to explain how the variable material is to be handled. Red-faced type is either illustrative "John Doe" information or the actual variables that will be made available. Numeric variables are shown in Green and range from minimum to maximum.

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: [c/o Authorized Administrator, Address 1, Address 2, City/State/Zip]

Product Name ← Actual name given to plan will be shown.

\$0 - \$50,000 Deductible Plan ← Included if deductible plan, otherwise deleted.

Major Medical Plan

Certificate of Coverage Number: BCS12345678← Actual certificate number shown here. Effective Date: 01/01/2011← Actual certificate/coverage effective date shown here.

This Plan is a Participating Provider Plan for major medical care.

V.

VI.

VII.

VIII.

Benefits: What the Plan Pays

Prescription Drug Benefits

General Provisions

Under this Plan, 4 Ever Life Insurance Company (Insurer) pays certain benefits at higher payment percentages when the services of a Participating Provider are used.

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit when it is in connection with a Medical Emergency.

The Insurance Coverage Area is any place that is outside the United States or anywhere in the world. The appropriate phrase will be shown here.

| Pres | ← officers change → ident | Secretary |
|------|-------------------------------|---------------------------------|
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| | Ac | tual page numbers will be shown |
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Exclusions and Limitations: What the Plan does not pay for

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I. Introduction

About This Plan

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

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

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

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

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

Providers in the U.S.: Covered Expenses for Participating Providers are based on the Insurer's Negotiated Rate. These Participating Providers have agreed to accept the Negotiated Rate as payment in full. Covered Expenses for Non-Participating Providers are based on Reasonable Charges, which may be less than actual billed charges. Non-Participating Providers can bill the Eligible Participant for amounts exceeding Covered Expenses. The Eligible Participant's personal financial cost may be considerably higher when he/she uses a Non-Participating Provider rather than a Participating Provider. Included if also coverage provided to insureds when in USA.

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.

OVERVIEW MATRIX

| | Limits | Limits | Limits | |
|--|---|--|--|--|
| | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. | |
| MEDICAL EXPENSES references to in | MEDICAL EXPENSES references to in-network or out of network included if cover persons while in US and PPO | | | |
| Deductible Any deductible paid for one column will be applied towards the deductible in another column. | Included if deductible applies→\$0 - \$10,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$25,000 per Family per Policy or Calendar Year. | Included if deductible applies→\$0 - \$10,000 per Insured Person per Policy or Calendar Year. Included if family plan→ and limited to \$0 - \$25,000 per Family per Policy or Calendar Year. Included if coverage provided within USA. | Included if deductible applies→\$0 - \$10,000 per Insured Person per Policy or Calendar Year. Included if family plan→ and limited to \$0 - \$25,000 per Family per Policy or Calendar Year. Included if coverage provided within USA. | |
| Payment Level One | Included if coinsurance applies→ Until the Coinsurance Maximum is satisfied, the Insurer will pay 75-100% of the Usual and Customary Fee. | Included if coinsurance applies→Until the Coinsurance Maximum is satisfied, the Insurer will pay 75-100% of the Usual and Customary Fee. ←Included if coverage provided within USA. | Included if coinsurance applies→Until the Coinsurance Maximum is satisfied, the Insurer will pay 75-100% of the Usual and Customary Fee.←Included if coverage provided within USA. | |
| Payment Level Two | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate. Included if coverage provided within USA. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. Included if coverage provided within USA. | |
| Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the deductible in another column. | Included if deductible→\$0 - \$50,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$100,000 per Family per Policy or Calendar Year. | Included if deductible→\$0 - \$50,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$100,000 per Family per Policy or Calendar Year. ← Included if coverage provided within USA. | Included if deductible→\$0 - \$50,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$100,000 per Family per Policy or Calendar Year. ← Included if coverage provided within USA. | |
| ACCIDENTAL DEATH AND DISMEMBERMENT | Maximum Benefit: Principal Sum up to \$10,000 - \$100,000 ← Include AD&D if selected by policyholder. | | | |
| REPATRIATION OF REMAINS | Maximum Benefit up to \$10,000 - \$50,000 ← Included Reparation benefit if selected by policyholder. | | | |
| MEDICAL EVACUATION | Maximum Lifetime Benefit for all Evacuations up to \$50,000 - \$1,000,000 ← Included if Medical Evacuation benefit selected by policyholder. | | | |
| BEDSIDE VISIT | | - \$10,000 for the cost of one economy of the Hospital Confinement for one (1 benefit selected by policyholder. | | |

SCHEDULE OF BENEFITS

(Subject to Maximums, Coinsurance, and Deductibles in Overview Matrix) These columns ψ included if coverage provided ψ within USA.

| Benefits | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. |
|--|---|---|---|
| Preventive Care Services – Deduct | ible is not applicable | | |
| For Dependent Children (Birth to Age 19) | 100% of the actual charges | 100% of the Negotiated Rate | All except a \$0 - \$100 Copayment / Overview Matrix, Payment Level 1 and/or Payment Level 2 |
| For Adults (Age 20 and Older) | 100% of the actual charges | 100% of the Negotiated Rate | All except a \$0 - \$100 Copayment / Overview Matrix, Payment Level 1 and/or Payment Level 2 |
| Services Provided by a Physician of applicable Shown if deductible does | or Provider – Copayments and Deduces not apply. | ctible applies ← Shown if deductible ap | oplies. Deductible is not |
| Surgical Care | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Medical Care | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Emergency Care | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Physician Office Visits | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Other Physician services | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Annual Physical Examination/Health screening for services not covered by Preventative Care ← Include if selected by policyholder | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$500 - \$1,000 and limited to one per Policy or Calendar Year. | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$500 - \$1,000 and limited to one per Policy or Calendar Year. | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$500 - \$1,000 and limited to one per Policy or Calendar Year. |
| Travel Vaccinations/Immunizations not covered under Preventative Care Services ← Include if selected by policyholder. | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$200 - \$500 per Policy or Calendar Year. Shown if policy or calendar year max applies. | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$200 - \$500 per Policy or Calendar Year. Shown if policy or calendar year max applies. | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$200 - \$500 per Policy or Calendar Year. ← Shown if policy or calendar year max applies. |
| Services and Supplies Provided by | Services and Supplies Provided by a Hospital – Copayments and Deductible apply if applicable | | |
| Inpatient Hospital Care | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |

| Benefits | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. |
|---|--|--|--|
| Outpatient Hospital Care | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Emergency Care ¹ | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Other Services and Special Conditi if Deductible does not apply | ions – Copayments <mark>and Deductible</mark> a | pply. ← Show if Deductible applies. D | eductible is not applicable. ← Show |
| Ambulance Transportation | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Ambulatory Surgical Facility | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Autism Spectrum Disorders | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Dental Care for an Accidental Injury | | % of Covered Expenses up to \$50 – \$* tooth limit applies → and limited to \$50 | |
| Maternity | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Mental Illnesses | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Chiropractic Care | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2 and limited to 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2 and limited to 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2 and limited to 6 – 50 visits per Policy or Calendar Year. |
| Physical/Occupational Therapy/Medicine | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2, and as many as 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2, and as many as 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2, and as many as 6 – 50 visits per Policy or Calendar Year. |
| Human Organ Transplants | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Infertility Treatment ← Included if selected by policyholder. | Limited to \$25,000 - \$100,000 per lifetime | Limited to \$25,000 - \$100,000 per lifetime | Limited to \$25,000 - \$100,000 per lifetime |
| Home Health Care ← Mandated offer; include if selected by policyholder. | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, <i>Include if per visit max applies</i> → up to a maximum of 10 – 180 visits per Policy <i>or</i> Calendar Year |
| Skilled Nursing Facilities | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, <i>Include if per visit max applies</i> → up to a maximum of 10 – 180 visits per Policy <i>or</i> Calendar Year |
| Hospice← Included if selected by policyholder. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |

| Benefits | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. |
|--|---|--------------------------------------|----------------------|
| Pharmacy – Outside the US Maximum 30 – 180 day supply | 100%> | of actual charge / the Copayment sta | ted below |
| Prescription Drugs | All except a \$5 - \$30 Copayment per prescription, per 30 day supply | | |
| 2. Injectables | All except a 10% - 30% Copayment per Prescription, per 30 day supply | | |
| Pharmacy – Inside the US Maximum 30 – 180 day supply | 50% - 100% of actual charge / the Copayment stated below | | |
| Generic Drugs | All except a \$5 - \$30 Copayment per prescription, per 30 day supply | | |
| 2. Brand name Drugs | All except a \$5 - \$30 Copayment per prescription, per 30 day supply | | |
| 3. Injectables | All except a 10% - 30% Copayment per Prescription, per 30 day supply | | |

| Hearing Services | No Deductible. 50% - 100% of Covered Expenses per Policy <i>or</i> Calendar Year up to a maximum of \$250 -\$1,000 for Hearing Services that are not the result of an Injury or Illness. ← <i>Include if elected by the policyholder</i> . In addition, for a Covered Person who is a Dependent Child under age 24. No Deductible. 50% - 100% of Covered Expenses up to a maximum of \$1,000 per Hearing Aid every three years. ← <i>Include if dependent children covered</i> . | |
|--|--|--|
| Vision Care ← Include Vision Care if selected by policyholder. | No Deductible. 50% - 100% of Covered Expenses per Policy <i>or</i> Calendar Year up to a maximum of \$250 - \$1,000 for Vision Care that is not the result of an Injury or Illness. | |
| Dental Care ← Include Dental Care if selected by policyholder. | Subject to a maximum Covered Expenses of \$500 - \$3,000 per Policy <i>or</i> Calendar Year. | |
| Preventive Dental Services | 100% of Actual Cost | |
| 2. Primary Dental Services | 100% - 50% of Actual Cost | |
| Major Dental Services | 100% - 50% of Actual Cost Major Dental Services are not covered during the first 3 - 6 months the Insured Person is insured. ← Include this limitation if selected by policyholder. | |
| Orthodontic Dental Care ← Include Orthodontic Dental Care if selected by policyholder. | No Deductible. 50% of Actual Cost up to a Lifetime Maximum of \$500 - \$3,000. Orthodontic expenses are not covered during the first 3 − 6 months the Insured Person is insured. ← Include this limitation if selected by policyholder. | |

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

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 an employee, 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 Employee

An Eligible Employee means a permanent full time employee or trainee, who usually works at least 20 – 40 hours a week in the conduct of the Group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis. *Included if eligible according to employer requirements and permitted by state.* An Eligible Employee does not include an employee who works on a part-time, temporary, or substitute basis. *or* An Eligible Employee may be a consultant or contractor engaged by the Group in the conduct of its business and works in the conduct of the Group's business at least 20 – 40 hours a week. *Included if eligible according to employer requirements and permitted by state.* An Eligible Employee also includes officers and directors of the Group regardless of the number of hours a week devoted to the conduct of the Group's business. *Included or deleted by agreement between the policyholder and the company.* An Eligible employee resides outside his/her Home Country and is scheduled to reside outside his/her Home Country for a period greater than 3 – 24 months.

If two members of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Group, then each must enroll separately as an Insured Participant. — Included or deleted by agreement between the policyholder and the company.

Eligible Dependents ← Include this entire provision if dependents covered.

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

- 1. spouse or civil union partner or domestic partner; Spouse and civil union partner included if dependents covered; domestic partner included if selected by the policyholder.
- 2. natural child, stepchild or legally adopted child who has not yet reached age 26 and includes dependents of a civil union or domestic partnership. Shown if domestic partnership coverage elected by policyholder,
- 3. own or spouse's or civil union partner's or domestic partner's ← Shown if domestic partnership coverage elected by policyholder. 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. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal quardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

As used above: ← Spouse and civil union partner included if dependents covered; domestic partner if selected by policyholder; combination of items 3a-f and 4a-g included based on state requirements for domestic partner and by agreement between the policyholder and the company; items 5 and 6 always included. ◆

- 1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
- 2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
- 3. The term "domestic partner" means a person of the same or opposite ← Shown if elected by policyholder, sex who:
 - a. is not married or legally separated;
 - b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
 - c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months:
 - d. occupies the same residence as the Eligible Participant;
 - e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
- f. as entered into a domestic partnership arrangement with the named Insured. \leftarrow Provision 3 in its entirety will not be shown if domestic partner coverage not elected by policyholder.
- 4. The term "domestic partnership arrangement means the Eligible Participant and another person of the same or opposite Shown if elected by policyholder. sex has any three of the following in common:
 - a. joint lease, mortgage or deed;
 - b. ioint ownership of a vehicle:
 - c. joint ownership of a checking account or credit account;

- d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
- e. designation of the domestic partner as a beneficiary of the employee's will;
- f. designation of the domestic partner as holding power of attorney for health care; or
- g. shared household expenses. ← Will not be shown if domestic partner coverage not elected by policyholder.
- 5. The term "civil union partner" means a person with whom the Eligible Participant has entered into a civil union in accordance with Vermont law.
- 6. The term "civil union" means that two eligible persons have established a relationship pursuant to Vermont Statute, Title 15, Chapter 23 and are thereby entitled to receive the benefits and protections and be subject to the responsibilities of spouses.

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

Additional Requirements for an Eligible Participant and Eligible Dependents

Included if dependents covered.: An Eligible Participant or an Eligible Dependent

Included if dependents covered. The Eligible Dependents Covered Depend

- 1. Citizen of the U.S. or permanent resident of the U.S. (as defined by the immigration code of the U.S.)
- 2. Employed by a company with offices in the U.S.
- 3. not a resident of the U.S.
- 4. his/her Home Country is not the U.S.
- 5. under Age 60 85.
- 6. enrolled in a Primary Plan.
- 7. Country of Assignment is other than the Eligible Participant's Home Country.
- ↑ Some combination of 1–7 by agreement between the policyholder and the company.

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. Applications will be accepted up to 30 days after the Initial Eligibility Date, however, —Included by agreement between the policyholder and the company. 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. Included if dependents covered.
 - 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 civil union partner or domestic partner ← Included if domestic partners covered. 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. ← Included if dependents covered.
 - c. <u>Adopted Children:</u> 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. Included if dependents covered.
 - 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. Included if dependents covered.
- 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.

Special Enrollment Periods ← Included or deleted this entire provision based on employer needs and consistency with other insurance programs in effect.

- 1. Eligible Participants who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they have other coverage may do so within 31 days after that other coverage terminates if the following requirements are met:
 - a. If the other coverage was COBRA continuation under another plan, that continuation must have been exhausted before the Eligible Participant may enroll the affected persons under this Plan.
 - b. If the other coverage was not COBRA continuation, then any employer contribution toward the cost of the coverage must have terminated or that coverage must itself have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:
 - i. legal separation or divorce;
 - ii. death:
 - ii. termination of employment or reduction in hours of employment.

The Eligible Participant must have declined enrollment for employee and/or dependent coverage during the Initial Enrollment Period by means of a written statement that the reason for declining enrollment was other coverage.

- 2. An Eligible Participant who did not enroll during the Initial Enrollment Period may enroll for participant and/or dependent coverage within 31 days after he or she marries or acquires an Eligible Dependent Child or Children by birth, adoption, or placement for adoption.
- 3. An Eligible Participant who did not enroll his or her spouse or civil union partner or domestic partner *Included if domestic partners covered.* during an Initial Enrollment Period may enroll that spouse within 31 days after the Eligible Participant acquires such new Dependent.

If an Eligible Participant does not apply within the 31 days of the Initial Enrollment Period or within the 31 days of a Special Enrollment Period as outlined above, he/she will become a Late Enrollee.

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;
- the date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
- 4. the date the Policy terminates;
- 5. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision.

Insured Dependents

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

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

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.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this Certificate or as specified below when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

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;
- on any premium due date for any of the following reasons. The Insurer must give the Group written notice of at least 30 days in advance if termination is due to:
 - a. failure to maintain the required minimum premium contribution;
 - b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
 - c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.
- 4. on any premium due date if the Insurer is also canceling all Group Health Benefit Plans in the state or in a geographic Service Area. The Insurer must give the Group written notice of cancellation:
 - a. at least 180 days in advance; and
 - b. again at least 30 days in advance.

Extension of Benefits

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

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

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

Continuation (COBRA)

Most employers in the United States who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law, which governs this provision the Insured Participant may also be entitled to a period of continuation of coverage under this Act. The Insured Participant should check with his/her employer for details.

III. Definitions

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

Accidental Injury means an accidental bodily Injury sustained by an Insured Person, which is the direct cause of a loss which is not the result of disease, bodily infirmity.

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

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

Age means the Insured Person's attained age.

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

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

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

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

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

Annual Open Enrollment Period is the 31-day period ending each Calendar Year on the anniversary of the Policy's Effective Date.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Autism Services Provider means any licensed or certified person providing treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder and Asperger's disorder. Diagnosis of Autism Spectrum Disorders means medically necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other testing to determine whether an individual has one or more Autism Spectrum Disorders. For purposes of this definition, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a licensed Physician or by Psychologist if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing.

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

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

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

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

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

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

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs. Includes medically-necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Chiropractor means a duly licensed chiropractor.

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

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

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

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

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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 {Policy/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 or are caused by the pregnancy, such as acute nephritis, nephrosis, cardiac decompression, missed abortion, 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 false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

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

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

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

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

Country of Assignment means the country for which the Eligible Participant has a valid 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.

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

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

Covered Person means the Insured, and any Eligible Dependents.

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

Creditable Coverage means coverage you had under any of the following:

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

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

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

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

Dentist means a duly licensed dentist.

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

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

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

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

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

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

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

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

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

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

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

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

Emergency (See Emergency Medical Care)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Habilitative Care or Rehabilitative Care means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals the provider has identified.

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

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

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

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

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

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

HTH means Highway to Health (d/b/a HTH Worldwide). This is the entity that provides the Insured Person with access to online databases of travel, health, and security information and online information about physicians and other medical providers outside the U.S.

An **Illness** is a sickness or disease of an Insured Person, which first manifests itself after the Insured Person's Effective Date and while coverage is in force.

Individual Coverage means coverage under this Certificate for yourself but not your spouse or civil union partner or domestic partner ← Included if domestic partners covered. and/or eligible dependent children.

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

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

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

Initial Enrollment Period is the 31 day period during which an Eligible 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)

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

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

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

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

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

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

Investigative Procedures (See Experimental/Investigational).

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

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

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

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

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

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

Medically Necessary (See exclusions section of this certificate)

Mental Health Care Professional means any person, corporation, facility or institution certified or licensed by this state to provide mental health care services, including but not limited to a physician, a nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such provider acting in the course and scope of employment or an agency related to mental health care services.

Mental Health Review Agent means a person or entity performing service review activities who is either affiliated with, under contract with, or acting on behalf of a business entity in the state of Vermont; or a third party who provides or administers mental health care benefits to citizens of Vermont, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care Physicians to coordinate delivery of services, authorized to offer health insurance policies or contracts in Vermont.

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient, or as approved by the Authorized Administrator. Mental Illness will also include Substance Abuse and the following biologically-based mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- 1. schizophrenia;
- 2. bipolar disorder;
- obsessive-compulsive disorder;
- 4. major depressive disorder;
- 5. panic disorder;
- 6. anorexia nervosa;
- 7. bulimia nervosa;
- 8. schizo-affective disorder; and
- 9. delusional disorder.

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

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

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

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

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

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

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

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

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

Occupational Therapist means a duly licensed occupational therapist.

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

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

- 1. History (gathering of information on an Illness or Injury).
- 2. Examination.

3. Medical Decision Making (the Physician's diagnosis and Plan of treatment). This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

Optometrist means a duly licensed optometrist.

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

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

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

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

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

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

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

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

Physical Therapist means a duly licensed physical therapist.

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

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits. Includes a licensed naturopathic physician working within the scope of his or license providing covered services or treatment.

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

Podiatrist means a duly licensed podiatrist.

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

Preexisting Condition means any condition for which medical advice or treatment was recommended by or received from a Physician within 6 months prior to the Coverage Date for the insured.

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

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

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

Psychologist means a Registered Clinical Psychologist.

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

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

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

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

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

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

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

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

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

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

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

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.

Speech Therapist means a duly licensed speech therapist.

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

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

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

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

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

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

Therapeutic Care means services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers for the Treatment of Autism Spectrum Disorders.

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

Treatment of Autism Spectrum Disorders means the following care prescribed, provided, or ordered for an individual diagnosed with one or more autism spectrum disorders by a licensed Physician or a licensed psychologist if such physician or psychologist determines the care to be medically necessary:

- 1. Habilitative Care or Rehabilitative Care;
- 2. pharmacy care;
- psychiatric care:
- 4. psychological care; and
- Therapeutic Care.

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

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

U.S. means the United States of America.

IV. How the Plan Works

The Insured Person's Plan pays a portion of his/her Covered Expenses after he/she meets his/her Deductible each Policy or Calendar Year. This section describes the Deductible and Copayments Show if Copayments apply. 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. — *Included if PPO involved.*

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.

Included if PPO involved.

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. — Included if PPO not involved.

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 or Calendar Year. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received from either Participating or Non-Participating Providers each Policy or Calendar Year before any benefits are available. The Annual Deductible does not apply to those Office Visits for which a Copayment is required. Annual maximum Deductibles (if any) for the Insured Eligible Participant and his/her Eligible Dependents is stated in the Overview Matrix.

Coinsurance Maximums

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

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

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

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

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

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

Plan Payment

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

First Level Payment

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

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

Second Level Payment

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

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

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

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

V. Benefits: What the Plan Pays

Before this Participating Provider — Include if PPO plan. 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 the Overview Matrix and the Schedule of Benefits.

Following is a general description of the supplies and services for which the Insured Person's Participating Provider Include if PPO plan. Plan will pay benefits, if such supplies and services are Medically Necessary. Whenever the term "you or your" is used, it is meant to mean all eligible Insured Person's as described in described under the Eligibility Section of this document.

Preventive Care Services

Benefits will be provided for preventive care services rendered to an Insured Person, even though they are not ill. Services described below received while outside the United States or inside the United States at an in-network provider will not be subject to a deductible, co-payment or co-insurance. Benefits will be limited to the following services:

Coverage for Preventative Items and Services

- 1. Except as otherwise provided in Subsection 2 below, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved:
 - a. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention:
 - b. With respect to infants, children and adolescents, evidence-informed preventive care, and screenings, including hearing loss screenings, provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - c. With respect to women, to the extent not described in Subsection 1.a., evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- 2. The Insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection 1 after the recommendation or guideline is no longer described in Subsection 1.
 - a. The Insurer will give sixty (60) days advance notice to the Eligible Participant before any material modification to the services in Subsection 1 become effective.

Additional Benefits Provided: Benefits will be limited to the following services:

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes. Benefits will be provided if these services are prescribed by a health care professional legally authorized to prescribe such training and education under law and rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management.

Benefits for such health care professionals will be provided at the same benefit levels as those provided for any other covered condition.

Diabetes Equipment and Supplies

Benefits are also available for diabetes equipment and supplies prescribed by a health care professional legally authorized to prescribe such equipment and supplies under law for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes.

Benefits for such equipment and supplies will be provided at the same benefit levels as those provided for any other covered condition

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or Pap smear test for females aged 18 and older.

Mammograms

- 1. a baseline mammogram for asymptomatic women at least 35 years of age;
- 2. a mammogram every 1 to 2 years for asymptomatic women age 40 to 50, but no sooner than 2 years after a baseline mammogram;
- 3. a mammogram every year for asymptomatic women age 50 and over.

Benefits will also be provided for any woman when a Physician's evaluation of a woman's physical conditions, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

Prostate Test and Digital Rectal Examination Benefits will be provided for routine prostate-specific antigen tests and digital rectal examinations in accordance with American Cancer Society guidelines.

Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening for persons 50 years of age or older. Screening includes:

- 1. An annual fecal occult blood tests (3 specimens).
- 2. A flexible sigmoidoscopy every 5 years.
- 3. A colonoscopy every 10 years.
- 4. A double contrast barium enema every 5 years.

In addition, benefits will be provided for people who are considered to be high risk for colon cancer because of:

- 1. Family history of familial adenomatous polyposis;
- 2. Family history of hereditary nonpolyposis colon cancer;
- 3. Chronic inflammatory bowel disease;
- 4. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- 5. A background, ethnicity or lifestyle is determined to be at elevated risk.

Annual Physical Examination/Health Screening

An Annual Physical Examination or Health Screening for services not covered under the Preventive Care Services above included in the coverage according to the limits stated in the Schedule of Benefits.

Included if selected by policyholder.

Travel Vaccinations/Immunizations

Recommended travel vaccinations/immunizations not covered under the Preventative Care Services above are covered according to the limits stated in the Schedule of Benefits. — *Included if selected by policyholder*.

Services Provided by a Physician

Surgery

Benefits are available for Surgery performed by a Physician or Dentist. However, for services performed by a Dentist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

- 1. surgical removal of complete bony impacted teeth; *Included if selected by policyholder*.
- 2. excisions of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, sali-vary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- 1. Anesthesia Services if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
- 2. Assistant Surgeon that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

After your Copayment, — *Included if copayment applies*. benefits for Surgery will be provided at the percent level shown in the Schedule of Benefits.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at the percentage of the Claim Charge as shown in the Schedule of Benefits. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

After your Copayment, — *Included if copayment applies.* benefits for Additional Surgical Opinion will be provided at the percent level shown in the Schedule of Benefits.

Medical Care

Benefits are available for Medical Care visits when:

- 1. you are an Inpatient in a Hospital or Substance Abuse Treatment Facility; or
- 2. you are a patient in a Partial Hospitalization Treatment Program; or
- 3. you visit your Physician's office or your Physician comes to your home.
- 4. After any Copayment, Medical Care Benefits are provided at the percent shown in the Schedule of Benefits.

Other Physician Services

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the **Other Services and Special Conditions** section of this Certificate.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Chemotherapy

The treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents. Your coverage also includes benefits for Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits. \(\leftarrow Included or deleted. \)

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits. Included or deleted.

Radiation Therapy Treatments

The treatment of disease by X-ray, radium, or radioactive isotopes.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association or similar body. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits will be provided as shown in the Schedule of Benefits. \(\lefta \) Included or deleted.

Diagnostic Service

Benefits will be provided for those services related to covered Surgery or Medical Care.

Benefit Payment for other Physician Services

After your Copayment, ← Included if copayment applies. benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits when you receive any of the Covered Services described in this Physician Benefit Section from a Provider or from a Dentist.

Emergency Accident or Medical Care

Treatment must occur within 72 hours of the accident.

Benefit Payment for Emergency Accident or Medical Care

After your Copayment, — *Included if copayment applies*. benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits.

Services and Supplies Provided by a Hospital

Inpatient Care

The following are Covered Services when the Insured Person receives them as an Inpatient in a Hospital. Whenever the Insured Person's Physician recommends a non-emergency or non-maternity Inpatient Hospital admission, you must call our Authorized Administrator. This call should be made

as far in advance as possible but not less than 5-7 business days prior to the Hospital admission. ← *Included or deleted based on employer plan specifications*.

Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits when you receive Inpatient Covered Services. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Inpatient Covered Services

- 1. Bed, Board and General Nursing Care when you are in:
 - a. a semi-private room
 - b. a private room (at semi-private room rate)
 - c. an intensive care unit
- 2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

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.
- 3. No benefits will be provided for personal items, such as TV, radio, quest trays, etc.

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery that you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

Parental Accommodation

Hospital charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12. Benefits are limited to a maximum of \$500 per inpatient admission. — *Included if selected by employer.*

Extension of Benefits in Case of Termination

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate that are rendered by and regularly charged for by a Hospital. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

Outpatient Hospital Care

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

- 1. Surgery and any related Diagnostic Service received on the same day as the Surgery
- 2. Radiation therapy treatments
- 3. MRI
- 4. Chemotherapy
- 5. Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
- Diagnostic Service when you are an Outpatient and these services are related to surgery or Medical Care
- 7. Emergency Accident Care treatment must occur within seventy-two (72) hours of the accident
- 8. Emergency Medical Care

Outpatient Hospital Care Benefit Payment

After you have met your Copayment, — Included if copayment applies. benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits.

Benefit Payment for Hospital Emergency Care

After you have met your Copayment, benefits will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits when you receive Emergency Accident Care or Emergency Medical Care.

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

The Authorized Administrator must be notified within 48 hours of admission for emergency care. ← Included or deleted based on employer plan specifications.

Other Covered Services and Special Conditions

Ambulance Transportation

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.

Non Covered Services for Ambulance include but are not limited to, trips to:

- 1. a Physician's office or clinic;
- 2. a morgue or funeral home.
- 3. for long distance trips or for use of an ambulance because it is more convenient than other transportation

Autism Spectrum Disorders - Diagnosis and Treatment in Covered Children

Coverage is provided for the diagnosis and Treatment of Autism Spectrum Disorders and includes Applied Behavior Analysis supervised by a nationally board-certified behavior analyst and provided by a licensed Autism Services Provider for children beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

Benefits are payable on the same basis as any other sickness.

Ambulatory Surgical Facility

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Ambulatory Surgical Facility for Outpatient Surgery will be provided as shown in the Schedule of Benefits.

Services for Mental Illness

Both inpatient and outpatient coverage is provided for the diagnosis and treatment of Mental Illness. Benefits for Mental Illness services are the same as benefits for any other condition as specified in the Schedule of Benefits.

Cancer Clinical Trials

Benefits will be provided for routine costs for Covered Persons who participate in approved cancer clinical trials conducted under the auspices of the following cancer care providers:

- 1. Vermont Cancer Center at Fletcher Allen Health Care;
- 2. The Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center; and
- 3. any Hospital and its affiliated, qualified cancer care providers.

For participation in clinical trials located outside Vermont, coverage under this benefit will be provided only if the Covered Person provides notice to the health benefit plan prior to participation in the clinical trial, and:

- 1. no clinical trial is available at a Vermont or New Hampshire cancer care provider described above;
- the Covered Person has already completed a clinical trial at an approved cancer care provider listed above and that provider has determined that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available at that time under an approved cancer care provider listed above; or
- 3. a. The health plan has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available; and
 - b. the patient's cancer care provider determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available under an approved cancer care provider listed above.

If a Covered Person participates in a clinical trial administered by a cancer care provider that is not in the health benefit plan's provider network, the health plan may require that routine follow-up care be provided within the health benefit plan's network, unless the cancer care provider determines this would not be in the best interest of the Covered Person.

As used in this benefit, "health benefit plan" means the Policy any other applicable health benefit plan offered by the Insurer.

Cardiac Rehabilitation Services

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.

Chiropractor Services

Exams, testing or manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractor Services as specified in the Schedule of Benefits.

Cleft Lip and Cleft Palate

Coverage shall be provided for Inpatient or Outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.

Dental Care for an Accidental Injury

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. No benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

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

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

Benefits are payable as stated in the Schedule of Benefits.

Durable medical equipment

Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose

Hormone Replacement Therapy

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

Human Organ Transplants

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

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

- for you. However, no benefits will be provided for the recipient.
- 4. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

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

- 1. Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.
- 2. Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
- 3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.
- 4. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
 - a. Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery
 - b. Transportation by air ambulance for the donor or the recipient
 - c. Travel time and related expenses required by a Provider
 - d. Drugs that are Investigational
 - e. The cost of acquisition of the organ and any costs incurred by the donor

Infertility← Include the Infertility benefits if selected by policyholder.

Covered services related to the diagnosis of infertility shall be same as any other condition.

Covered Services related to the treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer will be provided as shown in the Schedule of Benefits.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments;
- 2. you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Special Limitations for Infertility Services

Benefits will not be provided for the following:

- 1. Services rendered to a surrogate mother for purposes of childbirth
- 2. Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures that use a cryo-preserved substance
- Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization or other such body as approved by the Authorized Administrator.

Infusion Therapy

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

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

Covered Services for Infusion Therapy are as follows:

- 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.
- 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.

Medical Foods and Modified Food Products

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products when diagnosed and determined to be Medically Necessary by the Insured Person's Physician, and administered under the direction of a Physician.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry screened in newborn babies.

"Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means an amino acid modified preparation that is intended to be used under direction of a Physician for the dietary treatment of an inherited metabolic disease.

Ovarian Cancer Monitoring

Coverage shall be provided for CA-125 monitoring of ovarian cancer subsequent to treatment. This does not apply to routine screenings.

Other Covered Service

1. Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture

- 2. Allergy shots and allergy surveys
- 3. Blood and blood components
- 4. Leg, back, arm and neck braces
- 5. Oxygen and its administration
- 6. Medical and surgical dressings, supplies, casts and splints
- 7. Lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with guidelines set forth by the Division of Public Health
- 8. Scalp hair prosthesis Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease. Benefits are payable for up to \$500 per Policy or Calendar Year.

Pregnancy and Maternity Care

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Maternity benefits are **not** available for any Insured Person other than the Insured Participant or the Insured Participant's insured spouse or civil union partner or domestic partner — *Include if domestic partners covered*.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when our Authorized Administrator determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family

Prosthetic appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

- 1. they are required to replace all or part of an organ or tissue of the human body, or
- 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

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

Sterilization

The Insured Participant's Plan includes benefits for tubal ligation or vasectomy.

Treatment to Bones or Joints in the Face, Neck or Head

Benefits will be provided for the diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage will be:

- 1. the same as that provided under the Policy for any other musculoskeletal disorder in the body; and
- 2. provided when prescribed or administered by a Physician or a Dentist.

This benefit does not require coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

Home Health Care ← Mandated offer; include Home Health Care if selected by the policyholder.

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

Benefits are provided when the Insured Participant or Insured Dependents are confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. A visit is defined as four or fewer hours of services provided by one of the following providers:

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

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

Hospice Services ← *Included Hospice Services if selected by the policyholder.*

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

The Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is 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.

Services and Supplies Provided by a Skilled Nursing Facility

Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

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

Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:

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

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- 2. Skilled Nursing Facility admissions in excess of 10 180 days per Policy or Calendar Year.

Hearing Services

Hearing Services include audiometric exams, hearing aid evaluation test, and limited benefits for hearing aids. See the Schedule of Benefits for maximums, which apply for Hearing Services. \(\bigsec\) Included this coverage if selected by the policyholder.

For Covered Persons who are Dependent Children under age 24, coverage provided for hearing aids up to the amount shown in the Schedule of Benefits.

Encluded this coverage if dependent children covered.

Vision Care ← *Included Vision Care coverage if selected by the policyholder.*

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

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

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

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

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

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

Covered Services

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

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

Special Limitations

Benefits will not be provided for the following:

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

Benefit Payment for Vision Care

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

Dental Care ← *Included Dental Care coverage if selected by the policyholder.*

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

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

Any expenses incurred beyond the benefit maximum are your responsibility.

Preventative Dental Services

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

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

Primary Dental Services

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

- 1. Fillings
- 2. Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section

- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section
- 4. Endodontics
- 5. Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- 6. Apicoectomies
- 7. Hemisection
- 8. Biopsies of Oral Tissue
- 9. Periodontics/Periodontal Therapy; Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
- 10. Periodontal examination Benefits for periodontal examinations are limited to two per Benefit Period
- 11. Periodontal maintenance procedures Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
- 12. Stainless Steel Crowns
- 13. Repair of Removable Dentures
- 14. Recementing of Crowns, Inlays, Onlays and Bridges
- 15. General Anesthesia/Intravenous Sedation If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation
- 16. Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

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

Include this provision if elected by the policyholder.

Major Dental Services

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

- 1. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- 2. Fixed Bridgework
- 3. Bridge Repairs
- 4. Full and Partial Dentures
- 5. Denture Adjustments, Rebasing and Relining During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

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

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

Include this provision if elected by the policyholder.

Orthodontic Dental Care ← Include Orthodontic Dental Care if elected by the policyholder

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

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

Up to the age of 18, \(\subseteq \lncluded \) or deleted. Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. The limitations are as follows:

- 1. Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist;
- 2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
- 3. Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment

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

Orthodontic expenses are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits. Include this provision if selected by the policyholder.

Special Limitations

No benefits will be provided under this Benefit Section for:

- 1. Dental services which are performed for cosmetic purposes.
- 2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
- 3. Oral Surgery for the following procedures:
 - a. surgical services related to a congenital malformation;
 - b. surgical removal of complete bony impacted teeth;
 - c. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
- 4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
- 5. Hospital and ancillary charges are not covered.
- Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
- 7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

Accidental Death and Dismemberment Benefit ← Include AD&D Benefit if selected by the policyholder.

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

Loss Benefit

Loss of life100% of the Principal SumLoss of one hand50% of the Principal SumLoss of one foot50% of the Principal SumLoss of sight in one eye50% 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. — Included if selected by the policyholder.

Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Insured Persons in any one Accident or disaster shall not exceed the sum of \$300,000 - \$500,000. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed \$300,000 - \$500,000 the amount of indemnity payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed \$300,000 - \$500,000. In the event of any such Accident or disaster for which all indemnities payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed \$300,000 - \$500,000. In the event of any such Accident or disaster for which all indemnities payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed \$300,000 - \$500,000.

Repatriation of Remains Benefit Include Repatriation Benefit if selected by the policyholder.

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

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

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

Medical Evacuation Benefit ← Include Medical Evacuation Benefit if selected by the policyholder.

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 Overview Matrix, 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.

If you have minor children who are left unattended as a result of your injury, illness or medical evacuation, our Authorized Administrator will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to your Home Country or Country of Assignment.

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

Bedside Visit Benefit ← Include Bedside Visit Benefit if selected by the policyholder.

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than 3 – 7 days, is likely to be hospitalized for more than 3 – 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 3 – 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

1. The following services and supplies are not covered:

Hospitalization, services and supplies that are not Medically Necessary.

No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately
 in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Authorized Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Insurer will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Insurer, either at law or in equity. To initiate your appeal, you must give Insurer written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

Remember, even if your Physician prescribes, orders, recommends, approves or views hospitalization or other health care services and supplies as Medically Necessary, the Insurer will not pay for the hospitalization, services and supplies if its authorized administrator decides they were not Medically Necessary

2. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are provided under any Workers' Compensation Law or other similar laws. This exclusion does not apply to Protection and Indemnity Insurance for Marine crew

members. ← Included or deleted by agreement between the company and the policyholder

- 3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided by a local, state or federal government (except Medicaid).
- 4. Services and supplies for any illness or injury occurring on or after your Coverage date as a result of participation in war, riot, civil commotion or any illegal act.
- 5. Custodial Care Service.
- 6. Routine physical examinations, unless otherwise specified in this Certificate.
- 7. Cosmetic Surgery and related services and supplies, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease or the involved part, and reconstructive surgery because of a congenital diseases or anomaly of a covered dependent child which has resulted in a functional defect.
- 8. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- 9. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- 10. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- 11. Foot care, except for persons diagnosed with diabetes, in connection with corns, calluses, flat fee, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

 *- Included or deleted by agreement between the policyholder and the company.
- 12. Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.

 Included or deleted by agreement between the policyholder and the company.
- 13. Services and supplies to the extent benefits are duplicated because the spouse or civil union partner or domestic partner \(\bigcup \) Include if domestic partners covered, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- 14. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- 15. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- 16. Consultations performed by you, your spouse, civil union partner or domestic partner, parents or children.
- 17. Treatment for hair loss. ← Included or deleted by agreement between the policyholder and the company.
- 18. Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK). Included or deleted by agreement between the policyholder and the company.
- 19. Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate. ← Included or deleted by agreement between the policyholder and the company.
- 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.

 Included or deleted by agreement between the policyholder and the company.
- 21. Contact lenses and glasses unless otherwise specified in this Certificate.

 Included or deleted by agreement between the policyholder and the company.
- 22. Services and treatment related to elective abortions.

 Included or deleted by agreement between the policyholder and the company.
- 23. Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate. Included or deleted by agreement between the policyholder and the company.
- 24. Elective Abortions. ← Included or deleted by agreement between the policyholder and the company.
- 25. Dental services unless elected by your Group. Included or deleted by agreement between the policyholder and the company.
- 26. Vision care services unless elected by your Group. ← Included or deleted by agreement between the policyholder and the company.
- 27. Loss arising from ultra light aircraft *and/or* parasailing *and/or* sail planning *and/or* hang gliding.
- ↑ Numbering may change depending upon exclusions shown.

Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to pregnancy, congenital anomalies of a covered dependent, a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, or Insured Dependents under age 19.

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. — Included or deleted based on plan specifications.

VII. Prescription Drug Benefits ← Prescription Drug Benefits included if elected by the policyholder.

Introduction and Definitions

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

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

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

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

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

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

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. Call the Insured Person's local Pharmacy or call the toll-free Prescription Benefit Customer Service phone number x-xxx-xxxx-xxxx ← Actual phone number will be shown. for a list of Participating Pharmacies in the Insured Person's area.

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

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

Prescription drugs purchased in Canada, and used in Canada or re-imported legally or purchased through the I-SaveRx program, will be covered on the same benefit terms and conditions as prescription drugs purchased in the U.S.

Conditions of Service

The Drug or medicine must be:

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

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

The Prescription must not exceed a 30 – 180 -day supply.

Reimbursement

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

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

When the Insured Person Goes to a Participating Pharmacy

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

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 3. For injectable, the Insured Person pays as stated in the Schedule of Benefits.

For information on how to locate a Participating Pharmacy in the Insured Person's area, call x-xxx-xxxx-xxxx.

Actual phone number will be shown.

When the Insured Person Goes to a Non-Participating Pharmacy

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

When the Insured Person has his/her Prescription filled at a Non-Participating Pharmacy he/she will be reimbursed at the following rate for each covered Prescription and/or refill after the Insured Person's deductible is satisfied:

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

Claims and Customer Service

Drug claim forms are available at Participating Pharmacies or upon written request to Insurer.

If the Insured Person has any questions about his Prescription Drug Benefit, call the toll-free customer service number: **x-xxx-xxxx &** *Actual phone number will be shown.*

Prescription Drug Exclusions and Limitations bracketed exclusions included or removed and renumbered

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

- 1. Drugs and medications not requiring a Prescription, except insulin.
- 2. Self-administered injectable drugs, except insulin.
- 3. Non-medical substances or items.
- 4. Contraceptive Drugs and/or certain devices prescribed for birth control, ← Included if mandated unless employer objects due to religious reasons.
 Drugs and medications used to induce non-spontaneous abortions. ← Included if mandated unless employer objects due to religious reasons; if not mandated, included or deleted by agreement between the policyholder and the company.
- 5. Dietary supplements, cosmetics, health or beauty aids.
- 6. Any vitamin, mineral, herb or botanical product, which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
- 7. Drugs taken while the Eligible Participant are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
- 8. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
- 9. Syringes and/or needles, except those dispensed for use with insulin.
- 10. Durable medical equipment, devices, appliances and supplies.
- 11. Immunizing agents, biological sera, blood, blood products or blood plasma.
- 12. Oxygen.
- 13. Professional charges in connection with administering, injecting or dispensing of Drugs.
- 14. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
- 15. Drugs used for cosmetic purposes.
- 16. Drugs used for the primary purpose of treating infertility. ← Deleted if infertility covered.
- 17. Anorexiants or Drugs associated with weight loss.
- 18. Drugs obtained outside the United States. ← Included or deleted by agreement between the policyholder and the company.
- 19. Allergy desensitization products, allergy serum.
- 20. All Infusion Therapy is excluded under this Plan except as specifically stated in the Covered Services section.
- 21. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Preexisting Condition, or other contract limitation.
- 22. Growth Hormone Treatment.
- 23. Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
- 24. The replacement of lost or stolen Prescription Drugs. — Included or deleted by agreement between the policyholder and the company.
- 25. Antihistamines. ← Included if selected by the policyholder.

↑ Numbering may change depending upon exclusions shown.

VIII. General Provisions

Entire Contract; Changes

The Policy, including this Certificate and any attached endorsements and papers, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of coverage under the Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the Policy.

Grace Period

There is a Grace Period of 31 days allowed for the payment of each premium after the first premium, during which Grace Period coverage under the Policy shall continue in force.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

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 Policy Year, and are largely determined by 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;
- 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.
- 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.

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.

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.

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

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

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

The Claims Process

Notice of Claim: Within 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 has been received, the Insurer shall then have 15 working days within which to

process and either pay the claim or deny it, in whole or in part, giving the Insured Person the reasons the Insurer may have for denying such claim or any portion thereof.

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

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

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

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:

- 1. It is duly executed on a form acceptable to the Insurer; and
- 2. A copy is on file with the Insurer.

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

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

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

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

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

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

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

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

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

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

The Insurer's right to examine any records that exist:

- 1. During the time the Plan is in force; or
- 2. Until the Insurer pay the last claim.

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

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

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

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

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services.

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS.

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

Review and determination of mental health claims may only be made by a licensed Mental Health Review Agent with the concurrence of a Mental Health Care Professional whose training and expertise is at least comparable to that of the treating clinician.

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:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

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.

Appeal Process

Expedited Claim Appeal

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

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

First Level Appeal

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

Authorized Administrator ← Actual name of authorized administrator will be shown.

Address ← Actual address of authorized administrator will be shown.

City, State, zip code ← Actual address of authorized administrator will be shown.

Telephone number: ← Actual phone number will be shown.

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

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

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

Second Level Appeal

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

Authorized Administrator ← Actual name of authorized administrator will be shown.

Address ← Actual address of authorized administrator will be shown.

City, State, zip code ← Actual address of authorized administrator will be shown.

Telephone number: ← Actual phone number will be shown.

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

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

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

Independent External Review

When a Covered Person has exhausted all applicable internal review procedures provided by the Insurer, such Covered Person will have the right to an independent external review of any decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review will be available when requested in writing by the affected insured, provided the decision to be reviewed requires the Insurer to expend at least \$100.00 for the service and the decision by the plan is based on one of the following reasons:

- 1. The health care service is a covered benefit that the health insurer has determined to be not medically necessary.
- 2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and rules.
- 3. The health care treatment has been determined to be experimental, investigational or an off-label drug. A health benefit plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal, and shall decide such appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the commissioner.
- 4. The health care service involves a medically-based decision that a condition is preexisting.

The right to an independent review will not be construed to change the terms of coverage under the Policy.

The independent external reviews will be conducted:

- 1. By independent review organizations pursuant to a contract with the department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section; and
- 2. In accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

The Covered Person will:

- 1. be provided with adequate notice of their review rights under this section;
- 2. have the right to use outside assistance during the review process and to submit evidence relating to the health care service;
- 3. pay an application fee of \$25.00 for each request for an independent external review of an appealable decision not to exceed a total of \$75.00 annually. The application fee may be waived or reduced based on a determination by the Commissioner of Insurance that the financial circumstances of the Covered Person warrants a waiver or reduction. The application fee will be paid by the Insurer, not the Covered Person, if the independent review organization reverses the Insurer's decision to deny payment for a health care service; and
- 4. Be protected from retaliation for exercising their right to an independent external review.

Other costs of the independent review will be paid by the Insurer.

The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan.

The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable state or federal laws.

The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure in accordance with Vermont law.

Decisions relating to the following health care services shall not be reviewed under this section, but shall be reviewed by the review process provided by law:

- Health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan.
- 2. Health care services provided to inmates by the Department of Corrections.

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

[Product Name] MAJOR MEDICAL EXPENSE INSURANCE

POLICYHOLDER: [Employer]

POLICY EFFECTIVE DATE: [Month, Date, Year]

POLICY NUMBER: <###> ("the Policy")

STATE OF DELIVERY: Vermont

ADMINISTRATOR: [Authorized Administrator]

This Policy is a legal contract between the Policyholder and 4 Ever Life Insurance Company (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGRFFMFNT

This Policy, the Certificates issued under the policy, the application(s) of the Policyholder form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by an Insured Person, by the Insurer's Agent, or by any other person are not part of this Policy. Only the Insurer's President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Insured Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

POLICY TERM

Policy Effective Date: <MM/DD/YYYY>
Policy End Date: <MM/DD/YYYY>

Policy Termination Date: The Policy will continue in force for the while the required premiums are paid until the Policy End Date or the Policy is terminated by either the Policyholder or by the Insurer. At least <45 – 90> days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Group's coverage under the Policy may be cancelled at any time after <45 – 90> days written notice mailed or delivered by the Insurer to the Group or by the Group to the Insurer.

If the Insurer cancels the coverage under the Policy, the Insurer will mail or deliver the written notice to the Group at the last address stated in the Insurer's records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the <45th -91st > day after the Insurer mails or delivers the written notice.

If the Group cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Insured Person's period of coverage. No benefit is payable for charges incurred after the effective date of cancellation of coverage under the Policy, except as provided in the Policy's benefit provisions.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Cancellation of Insured Person's Coverage: An Insured Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.

Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly, semi-annually, annually, or for a specified term less than one year. Coverage will terminate if the required premium is not paid to the Insurer, subject to the Grace Period. Premium is charged from the date insurance for each Insured Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Premium Due Dates: The Insured Person's first premium is due and payable on the Insured Person's Effective Date of Coverage.

Change in Premium: The Insurer may change the premiums due on or after the first Policy Anniversary Date. The Insurer shall give written notice of such change at least 60 days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended. If the Insurer changes rates, the change will apply only to coverage starting on or after the effective date of the change. The Insurer will give the Policyholder at least 31 days advance written notice of any change.

INDIVIDUAL CERTIFICATES

The Insurer will furnish to the Policyholder, for delivery to each Eligible Participant, an individual certificate setting forth in substance the essential features of the insurance coverage of such Eligible Participants and to whom benefits thereunder are payable.

NEW MEMBERS

New Members: Eligible new employees and dependents may be added to the Group Policy, in accordance with the terms of the Policy and the attached Certificate.

GENERAL PROVISIONS

Entire Contract; **Changes**: This Policy, including the Certificate and any attached endorsements and papers, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses:

- (a) After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy, shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two year period.
- (b) No claim for loss incurred or disability (as defined in this Policy) commencing after two years from the effective date of coverage under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under this Policy.

Grace Period: There is a Grace Period of 31 days allowed for the payment of each premium after the first premium, during which Grace Period this Policy shall continue in force.

Reinstatement: If any renewal premium be not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any of Our agents duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy; provided, however, that if We or Our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten days after such date. In all other respects the Policyholder and We shall have the same rights hereunder as We both had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

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.

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

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

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

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

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

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

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

Physical Examination 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.

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.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of 4 Ever Life Insurance Company.

HFBLackam, II

GROUP INSURANCE POLICY
PROVIDING ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable

Form 54.1201 ER VT 20120404 redline Page 3

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: [c/o Authorized Administrator, Address 1, Address 2, City/State/Zip]

[Product Name] HTH Group Insurance Plan

[<\$0 - \$10,000> Deductible Plan] Major Medical Plan

Certificate of Coverage Number: Effective Date:

This Plan is a Participating Provider Plan for major medical care.

Under this Plan, 4 Ever Life Insurance Company (Insurer) pays certain benefits at higher payment percentages when the services of a Participating Provider are used.

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit when it is in connection with a Medical Emergency.

The Insurance Coverage Area is any place that is {within the United States /outside the United States/anywhere in the world}.

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I. Introduction

About This Plan

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

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

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

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

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

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 [Authorized Administrator Name] as its administrator.

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. [Authorized Administrator Name] provides a list to Eligible Participants of Foreign Country Providers with whom [Authorized Administrator Name] 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 [Authorized Administrator Name] is able to provide background information and to arrange access for Insured Persons.

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

[Authorized Administrator/4 Ever Life Insurance Company] has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services inside the United States, Puerto Rico, or the United States Virgin Islands, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between [Authorized Administrator/4 Ever Life Insurance Company] and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care inside the United States, Puerto Rico, and the United States Virgin Islands, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). In some instances, you may obtain care from providers that do not contract with the Host Blue (non-participating healthcare providers). [Authorized Administrator/4 Ever Life Insurance Company's] payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, [Authorized Administrator/4 Ever Life Insurance Company] will remain responsible for fulfilling [Authorized Administrator/4 Ever Life Insurance Company] contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to [Authorized Administrator/4 Ever Life Insurance Company].

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

discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price [Authorized Administrator/4 Ever Life Insurance Company] use[s] for your claim because they will not be applied retroactively to claims already paid.

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

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

1. Member Liability Calculation

When covered healthcare services are provided inside the United States, Puerto Rico, or the United States Virgin Islands by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment [Authorized Administrator/4 Ever Life Insurance Company] will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, [Authorized Administrator/4 Ever Life Insurance Company]may use other payment bases, such as billed covered charges, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount [we/Licensee Name] will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment [Authorized Administrator/4 Ever Life Insurance Company] will make for the covered services as set forth in this paragraph.]

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.

OVERVIEW MATRIX

| | Limits Outside the U.S. | [Limits In Network, U.S.] | [Limits Out-of-Network, U.S.] |
|---|---|--|--|
| MEDICAL EXPENSES | | | |
| Deductible Any deductible paid for one column will be applied towards the deductible in another column. | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] |
| Payment Level One | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75 - 100%> of the Usual and Customary Fee.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75 - 100%> of the Negotiated Rate.] | [[Until the Coinsurance Maximum is satisfied.] the Insurer will pay <75-100%> of the Usual and Customary Fee.] |
| Payment Level Two | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. |
| Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the deductible in another column. | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] |
| [ACCIDENTAL DEATH AND DISMEMBERMENT | Maximum Benefit: Principal Sum up to <\$10,000 - \$100,000>] | | |
| [REPATRIATION OF REMAINS | Maximum Benefit up to <\$10,000 - \$50,000>] | | |
| [MEDICAL EVACUATION | Maximum Lifetime Benefit for all Evacuations up to <\$50,000 - \$1,000,000>] | | |
| [BEDSIDE VISIT | Up to a maximum benefit of <\$1,000 - \$10,000> 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 [In Network, U.S.] [Out-of-Network, U.S.] Outside the U.S. Preventive Care Services – Deductible is not applicable (All except a <\$0 - \$100> For Dependent Children 100% of the Usual and Customary Copayment / (Overview Matrix, 100% of the Negotiated Rate Fee [Payment Level 1][and Payment (Birth to Age 19) Level 2] inserted here)} (All except a <\$0 - \$100> For Adults Copayment / (Overview Matrix, 100% of the Usual and Customary 100% of the Negotiated Rate [Payment Level 1][and Payment Fee (Age 20 and Older) Level 2] inserted here)} Services Provided by a Physician or Provider – Copayments [[and Deductible apply] if applicable unless specifically stated /Deductible is not applicable] [Deductible does not apply] [{After [Deductible does not apply] [Deductible does not apply] a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, **Physician Office Visits** (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted here)} here)} here)} [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level **Surgical Care** 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted here)} here)} [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level **Medical Care** 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted here)} here)} here)} $[{After a < $0 - $100 > Copayment}][,$ [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level **Emergency Care** 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted here)} here)} here)} [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level Other Physician services 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted here)} here)} here)} [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level [Annual Physical 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted Examination/Health screening 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 here)}up to a Maximum of <\$500 here))up to a Maximum of <\$500 for services not covered by \$1,000> and limited to one per \$1,000> and limited to one per \$1,000> and limited to one per **Preventative Carel** {Policy/Calendar} Year. {Policy/Calendar} Year. {Policy/Calendar} Year.] [{After a <\$0 - \$100> Copayment][, [$\{After \ a < \$0 - \$100 > Copayment][$ [{After a <\$0 - \$100> Copayment][, [Travel (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level Vaccinations/Immunizations not 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted covered under Preventative here)}[up to a Maximum of <\$200 here))[up to a Maximum of <\$200 here))[up to a Maximum of <\$200 -Care Services] \$500> per {Policy/Calendar} Year.] \$500> per {Policy/Calendar} Year] \$500> per {Policy/Calendar} Year] Services and Supplies Provided by a Hospital - Copayments and Deductible apply if applicable, unless specifically stated (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted Inpatient Hospital Care here) here) (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted 1][and Payment Level 2] inserted **Outpatient Hospital Care**

here)

here)

here)

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | |
|---|--|--|--|--|
| Emergency Care ¹ | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Other Services and Special Condition | ions - Copayments [[and Deductible | apply] if applicable, unless specifica | ally stated | |
| Ambulance Transportation | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Ambulatory Surgical Facility | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Autism Spectrum Disorders | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Dental Care for an Accidental Injury | Same as any Injury / <50% - 100%> of Covered Expenses up to <\$50 – \$1,000> per Policy Year maximum [and limited to <\$50 – 200> per tooth] | | | |
| Maternity | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Mental Illnesses | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Chiropractic Care | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 - 50> visits per {Policy/Calendar} Year | [Deductible does not apply] {After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 - 50> visits per {Policy/Calendar} Year [| |
| Physical/Occupational/Speech Therapy/Medicine and Other Specified Therapies | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | |
| Infusion Therapy/Radiation Therapy/Chemotherapy | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Human Organ Transplants | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| [Infertility Treatment | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime] | |
| Home Health Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | |
| Skilled Nursing Facilities | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | |
| Hospice | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | |

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | |
|---|--|--------------------|------------------------|--|
| | here) | here) | here) | |
| Pharmacy Benefits | | | | |
| Pharmacy – Outside the US Maximum <30 – 180> day supply | {<50% - 100%> of actual charge / the Copayment stated below} | | | |
| Prescription Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | |
| 2. Injectables | All except a <10% - 30% Copayment per Prescription, per 30 day supply] | | | |
| Pharmacy – Inside the US Maximum <30 – 180> day supply | {<50% - 100%> of actual charge / the Copayment stated below} | | | |
| Generic Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | |
| 2. Brand name Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | |
| 3. Injectables | All except a <10% - 30% Copayment per Prescription, per 30 day supply] | | | |
| Hearing Services | No Deductible. <50% - 100%> of Covered Expenses per Policy Year up to a maximum of \$500 for Hearing Services that are not the result of an Injury or Illness. In addition, for a Covered Person who is a Dependent Child under age 24, 100% of Covered Expenses up to a maximum of \$1,000 per Hearing Aid every three years. | | | |
| [Vision Care | No Deductible. <50% - 100%> of Covered Expenses per Policy Year up to a maximum of <\$250 -\$1,000> for Vision Care that is not the result of an Injury or Illness.] | | | |
| [Dental Care | Subject to a maximum Covered Expenses of <\$500 - \$3,000> per {Policy/Calendar} Year. | | | |
| Preventive Dental Services | 100% of Actual Cost | | | |
| Primary Dental Services | <100% - 50%> of Actual Cost | | | |
| Major Dental Services | <100% - 50%> of Actual Cost [Major Dental Services are not covered during the first <3 - 6> months the Insured Person is insured.] | | | |
| [Orthodontic Dental Care | No Deductible. 50% of Actual Cost up to a Lifetime Maximum of <\$500 - \$3,000> [Orthodontic expenses are not covered during the first <3 – 6> months the Insured Person is insured.] | | | |

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

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], [employee], 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 Employee

An Eligible Employee means a permanent full time employee or trainee, who usually works at least <20 – 40> hours a week in the conduct of the Group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis. [An Eligible Employee does not include an employee who works on a part-time, temporary, or substitute basis.] [An Eligible Employee may be a consultant or contractor engaged by the Group in the conduct of its business and works in the conduct of the Group's business at least <20 – 40> hours a week.] [An Eligible Employee also includes officers and directors of the Group regardless of the number of hours a week devoted to the conduct of the Group's business.] [An Eligible employee resides outside his/her Home Country and is scheduled to reside outside his/her Home Country for a period greater than <3 – 24> months.]

[If two members of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Group, then each must enroll separately as an Insured Participant.]

[Eligible Dependents

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

- 1. Spouse, or civil union partner, [or domestic partner]:
- 2. natural child, stepchild or legally adopted child and includes a dependent of a civil union [or domestic partnership] who has not yet reached age 26;
- 3. own or spouse's or civil union partner's or domestic partner'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 or spouse/partner. 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. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.]

[As used above:

- 1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
- 2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
- 3. The term "domestic partner" means a person of the same or opposite sex who:
 - a. is not married or legally separated;
 - b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
 - is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months:
 - d. occupies the same residence as the Eligible Participant;
 - e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
 - f. as entered into a domestic partnership arrangement with the named Insured.
- 4. The term "domestic partnership arrangement means the Eligible Participant and another person of the same or opposite sex has any three of the following in common:
 - a. joint lease, mortgage or deed;
 - b. joint ownership of a vehicle;
 - joint ownership of a checking account or credit account;
 - d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
 - e. designation of the domestic partner as a beneficiary of the employee's will;
 - f. designation of the domestic partner as holding power of attorney for health care; or
 - g. shared household expenses.
- 5. The term "civil union partner" means a person with whom the Eliqible Participant has entered into a civil union in accordance with Vermont law.
- 6. The term "civil union" means that two eligible persons have established a relationship pursuant to Vermont Statute, Title 15, Chapter 23 and are thereby entitled to receive the benefits and protections and be subject to the responsibilities of spouses.]

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. [Citizen of the U.S. or permanent resident of the U.S. (as defined by the immigration code of the U.S.)]
- 2. [Employed by a company with offices in the U.S.]
- 3. [not a resident of the U.S.]
- 4. [his/her Home Country is not the U.S.]
- 5. [under Age <60 85>].
- 6. [Country of Assignment is other than the Eligible Participant's Home Country.]

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. [Applications will be accepted up to 30 days after the Initial Eligibility Date, however,] 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. <u>Newborn Children:</u> 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. <u>Court Ordered Coverage for a Dependent:</u> If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is a spouse or civil union partner [or domestic partner] 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. <u>Adopted Children:</u> 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.

[Special Enrollment Periods

- Eligible Participants who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they have other coverage may do so within 31 days after that other coverage terminates if the following requirements are met:
 - a. If the other coverage was COBRA continuation under another plan, that continuation must have been exhausted before the Eligible Participant may enroll the affected persons under this Plan.
 - b. If the other coverage was not COBRA continuation, then any employer contribution toward the cost of the coverage must have terminated or that coverage must itself have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:

- legal separation or divorce;
- ii. death:
- ii. termination of employment or reduction in hours of employment.

The Eligible Participant must have declined enrollment for employee and/or dependent coverage during the Initial Enrollment Period by means of a written statement that the reason for declining enrollment was other coverage.

- 2. An Eligible Participant who did not enroll during the Initial Enrollment Period may enroll for participant and/or dependent coverage within 31 days after he or she marries or acquires an Eligible Dependent Child or Children by birth, adoption, or placement for adoption.
- 3. An Eligible Participant who did not enroll his or her spouse or civil union partner [or domestic partner] during an Initial Enrollment Period may enroll that spouse or civil union partner [or domestic partner] within 31 days after the Eligible Participant acquires an Eligible Dependent Child or Children by birth or adoption or placement for adoption.

If an Eligible Participant does not apply within the 31 days of the Initial Enrollment Period or within the 31 days of a Special Enrollment Period as outlined above, he/she will become a Late Enrollee.]

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 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:

- the date the Insured Participant's Insured Dependent no longer meets the definition of an Eligible Dependent as defined in the Planthe end of the
 period for which premium payment has been made to the Insurer;
- 2. the date the Policy terminates;
- 3. the date the Insured Participant's coverage terminates;
- 4. 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.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits" provisions of this Certificate or as specified below when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

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;
- on any premium due date for any of the following reasons. The Insurer must give the Group written notice of at least 30 days in advance if termination is due to:
 - a. failure to maintain the required minimum premium contribution;

- b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
- c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.
- 4. on any premium due date if the Insurer is also canceling all Group Health Benefit Plans in the state or in a geographic Service Area. The Insurer must give the Group written notice of cancellation:
 - a. at least 180 days in advance; and
 - b. again at least 30 days in advance.

Extension of Benefits

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

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

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

[Continuation (COBRA)

Most employers in the United States who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law, which governs this provision the Insured Participant may also be entitled to a period of continuation of coverage under this Act. The Insured Participant should check with his/her employer for details.]

III. Definitions

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

Accidental Injury means an accidental bodily Injury sustained by an Insured Person, which is the direct cause of a loss and which is not the result of disease or bodily infirmity.

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

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

Age means the Insured Person's attained age.

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

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

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

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

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

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Autism Services Provider means any licensed or certified person providing treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder and Asperger's disorder.

Diagnosis of Autism Spectrum Disorders means medically necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other testing to determine whether an individual has one or more Autism Spectrum Disorders. For purposes of this definition, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a licensed Physician or by Psychologist if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing.

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

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

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

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

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

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

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs. Includes medically-necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Chiropractor means a duly licensed chiropractor.

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

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider.

Claim Payment means the benefit payment calculated by the Insurer, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider.

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

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulates the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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 {Policy/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 or are caused by pregnancy, isuch as acute nephritis, nephrosis, cardiac decompression, missed abortion, 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 false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

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

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

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

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. Reconstructive Surgery is surgery to correct the appearance of abnormal

looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons**.

Country of Assignment means the country for which the Eligible Participant has a valid 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.

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

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

Covered Person means the Insured, and any Eligible Dependents.

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

Creditable Coverage means coverage you had under any of the following:

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

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

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

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

Dentist means a duly licensed dentist.

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

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

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

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

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

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

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

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

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

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

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

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

Emergency (See Emergency Medical Care)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Habilitative Care or Rehabilitative Care means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals the provider has identified.

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

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

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

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, or the local/national authority if outside the United States.

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 or the local/national authority if outside the United States.

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

An **Illness** is a sickness or disease of an Insured Person, which first manifests itself after the Insured Person's Effective Date and while coverage is in force.

Individual Coverage means coverage under this Certificate for yourself but not your spouse or civil union partner [or domestic partner].and/or eligible dependent children.

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

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

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

Initial Enrollment Period is the 31 day period during which an Eligible 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)

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

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

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

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Plan. Insured Participant is also referred to as 'you'.

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

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

Investigative Procedures (See Experimental/Investigational).

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

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

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

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

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

Medical care means:

- 1. The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
- 2. Transportation primarily for and essential to medical care referred to in Paragraph (1).

Medically Necessary (See exclusions section of this certificate)

Mental Health Care Professional means any person, corporation, facility or institution certified or licensed by this state to provide mental health care services, including but not limited to a physician, a nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such provider acting in the course and scope of employment or an agency related to mental health care services.

Mental Health Review Agent means a person or entity performing service review activities who is either affiliated with, under contract with, or acting on behalf of a business entity in the state of Vermont; or a third party who provides or administers mental health care benefits to citizens of Vermont, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care Physicians to coordinate delivery of services, authorized to offer health insurance policies or contracts in Vermont.

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient, or as approved by the Authorized Administrator. Mental Illness will also include Substance Abuse and the following biologically-based mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- schizophrenia;
- 2. bipolar disorder:
- obsessive-compulsive disorder;
- 4. major depressive disorder;
- panic disorder;
- anorexia nervosa;
- 7. bulimia nervosa;
- 8. schizo-affective disorder; and
- 9. delusional disorder.

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

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

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

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

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

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

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

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

Nursing at Home Care Program means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on

an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Occupational Therapist means a duly licensed occupational therapist.

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

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

- 1. History (gathering of information on an Illness or Injury).
- Examination.
- Medical Decision Making (the Physician's diagnosis and Plan of treatment).

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

Optometrist means a duly licensed optometrist.

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

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

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

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

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

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

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

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

Physical Therapist means a duly licensed physical therapist.

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

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits.

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits. Includes a licensed naturopathic physician working within the scope of his or license providing covered services or treatment.

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

Podiatrist means a duly licensed podiatrist.

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

Preexisting Condition means any condition for which medical advice or treatment was recommended by or received from a legally qualified physician within 6 months prior to the Coverage Date for the insured.

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

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

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

Psychologist means a Registered Clinical Psychologist.

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

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

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

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

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

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

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

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

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

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

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

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

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.

Speech Therapist means a duly licensed speech therapist.

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

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

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

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

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

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

Therapeutic Care means services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers for the Treatment of Autism Spectrum Disorders.

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

Treatment of Autism Spectrum Disorders means the following care prescribed, provided, or ordered for an individual diagnosed with one or more autism spectrum disorders by a licensed Physician or a licensed psychologist if such physician or psychologist determines the care to be medically necessary:

- 1. Habilitative Care or Rehabilitative Care;
- 2. pharmacy care;
- psychiatric care;
- 4. psychological care; and
- 5. Therapeutic Care.

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

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

U.S. means the United States of America, including Puerto Rico and the US Virgin Islands.

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 {Policy/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/Calendar} Year. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received from either Participating or Non-Participating Providers each {Policy/Calendar} Year before any benefits are available. The Annual Deductible does not apply to those Office Visits for which a Copayment is required. Annual maximum Deductibles (if any) for the Insured Eligible Participant and his/her Eligible Dependents is stated in the Overview Matrix.

Coinsurance Maximums

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

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

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

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

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

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

Plan Payment

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

First Level Payment

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

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

Second Level Payment

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

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

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

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 the Overview Matrix and the Schedule of Benefits.

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. Whenever the term "you or your" is used, it is meant to mean all eligible Insured Person's as described in described under the Eligibility Section of this document.

Preventive Care Services

Benefits will be provided for preventive care services rendered to an Insured Person, even though they are not ill. Services described below received while outside the United States or inside the United States at an in-network provider will not be subject to a deductible, co-payment or co-insurance. Benefits will be limited to the following services:

Coverage for Preventative Items and Services

- Except as otherwise provided in Subsection 2 below, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved:
 - a. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
 - b. With respect to infants, children and adolescents, evidence-informed preventive care, and screenings, including hearing loss screenings, provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - c. With respect to women, to the extent not described in Subsection 1.a., evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- 2. The Insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection 1 after the recommendation or guideline is no longer described in Subsection 1.
 - a. The Insurer will give sixty (60) days advance notice to the Eligible Participant before any material modification to the services in Subsection 1 become effective.

Additional Benefits Provided: Benefits will be limited to the following services:

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes. Benefits will be provided if these services are prescribed by a health care professional legally authorized to prescribe such training and education under law and rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management.

Benefits for such health care professionals will be provided at the same benefit levels as those provided for any other covered condition.

Diabetes Equipment and Supplies

Benefits are also available for diabetes equipment and supplies prescribed by a health care professional legally authorized to prescribe such equipment and supplies under law for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes.

Benefits for such equipment and supplies will be provided at the same benefit levels as those provided for any other covered condition.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or Pap smear test for females aged 18 and older.

Mammograms

- 1. a baseline mammogram for asymptomatic women at least 35 years of age;
- 2. a mammogram every 1 to 2 years for asymptomatic women age 40 to 50, but no sooner than 2 years after a baseline mammogram;
- 3. a mammogram every year for asymptomatic women age 50 and over.

Benefits will also be provided for any woman when a Physician's evaluation of a woman's physical conditions, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

Prostate Test and Digital Rectal Examination Benefits will be provided for routine prostate-specific antigen tests and digital rectal examinations in accordance with American Cancer Society guidelines.

Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening for persons 50 years of age or older. Screening includes:

- An annual fecal occult blood tests (3 specimens).
- 2. A flexible sigmoidoscopy every 5 years.
- 3. A colonoscopy every 10 years.
- 4. A double contrast barium enema every 5 years.

In addition, benefits will be provided for people who are considered to be high risk for colon cancer because of:

- 1. Family history of familial adenomatous polyposis;
- 2. Family history of hereditary nonpolyposis colon cancer;
- 3. Chronic inflammatory bowel disease;
- 4. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- 5. A background, ethnicity or lifestyle is determined to be at elevated risk.

[Annual Physical Examination/Health Screening

An Annual Physical Examination or Health Screening for services not covered under the Preventive Care Services above included in the coverage according to the limits stated in the Schedule of Benefits.]

[Travel Vaccinations/Immunizations

Recommended travel vaccinations/immunizations not covered under the Preventative Care Services above are covered according to the limits stated in the Schedule of Benefits.]

Services Provided by a Physician

Surgery

Benefits are available for Surgery performed by a Physician or Dentist. However, for services performed by a Dentist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

- 1. [surgical removal of complete bony impacted teeth;]
- 2. excisions of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- 1. Anesthesia Services if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
- 2. Assistant Surgeon that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

Benefits for Surgery will be provided at the percent level shown in the Schedule of Benefits.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at the percentage of the Claim Charge as shown in the Schedule of Benefits. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

[After your Copayment,] Benefits for Additional Surgical Opinion will be provided at the percent level shown in the Schedule of Benefits.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital or Substance Abuse Treatment Facility; or

- 2. you are a patient in a Partial Hospitalization Treatment Program; or
- 3. you visit your Physician's office or your Physician comes to your home.
- 4. After any Copayment, Medical Care Benefits are provided at the percent shown in the Schedule of Benefits.

Other Physician Services

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the **Special Conditions & Payments** section of this Certificate.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Chemotherapy

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits for any Physician or Hospital charges associated with treatment. Your coverage includes benefits for Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits.

Radiation Therapy treatments

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits for any Physician or Hospital charges associated with treatment.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association or similar body. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits will be provided as shown in the Schedule of Benefits.

Other Specified Therapies

Benefits will be provided as shown in the Schedule of Benefits for other Specified Therapies, which include: Biofeedback, Chelation Therapy, Hearing Therapy, Orthoptics & Vision Therapy, Pulmonary and Respiratory Rehabilitation. Services must be rendered by a licensed Provider and must be prescribed to treat a covered illness or injury.

Diagnostic Service

Benefits will be provided for those services related to covered Surgery or Medical Care.

Benefit Payment for other Physician Services

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits when you receive any of the Covered Services described in this Physician Benefit Section from a Provider or from a Dentist.

Emergency Accident or Medical Care

Treatment must occur within 72 hours of the accident.

Benefit Payment for Emergency Accident or Medical Care

[After your Copayment,] Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits.

Services and Supplies Provided by a Hospital

Inpatient Care

The following are Covered Services when the Insured Person receives them as an Inpatient in a Hospital.

Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits when you receive Inpatient Covered Services. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Inpatient Covered Services

- 1. Bed, Board and General Nursing Care when you are in:
 - a. a semi-private room
 - b. a private room (at semi-private room rate)
 - c. an intensive care unit
- 2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Payment of Inpatient Covered Expenses are subject to these conditions:

- 1. Services must be those, which are regularly provided and billed by the Hospital.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.
- 3. No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery that you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

[Parental Accommodation

Hospital charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12. Benefits are limited to a maximum of \$500 per inpatient admission.]

Extension of Benefits in Case of Termination

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate that are rendered by and regularly charged for by a Hospital. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

Outpatient Hospital Care

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

- Surgery and any related Diagnostic Service received on the same day as the Surgery
- 2. Radiation therapy treatments
- 3. MRI
- 4. Chemotherapy
- 5. Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
- 6. Diagnostic Service when you are an Outpatient and these services are related to surgery or Medical Care
- 7. Emergency Accident Care treatment must occur within seventy-two (72) hours of the accident
- 8. Emergency Medical Care

Outpatient Hospital Care Benefit Payment

[After you have met your Copayment,] Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits.

Benefit Payment for Hospital Emergency Care

After you have met your Copayment, benefits will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits when you receive Emergency Accident Care or Emergency Medical Care.

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

Other Covered Services and Special Conditions

Ambulance Transportation

The following ambulance services are covered under this Plan:

- 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.

Non Covered Services for Ambulance include but are not limited to, trips to:

- 1. a Physician's office or clinic;
- 2. a morgue or funeral home.
- 3. for long distance trips or for use of an ambulance because it is more convenient than other transportation

Ambulatory Surgical Facility

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Ambulatory Surgical Facility for Outpatient Surgery will be provided as shown in the Schedule of Benefits.

[Autism Spectrum Disorders - Diagnosis and Treatment in Covered Children

Coverage is provided for the diagnosis and Treatment of Autism Spectrum Disorders and includes Applied Behavior Analysis supervised by a nationally board-certified behavior analyst and provided by a licensed Autism Services Provider for Covered Dependents beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

Benefits are payable on the same basis as any other sickness.

Services for Mental Illnesses

Both inpatient and outpatient coverage is provided for the diagnosis and treatment of Mental Illness. Benefits for Mental Illness services are the same as benefits for any other condition as specified in the Schedule of Benefits.

Cardiac Rehabilitation Services

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.

Chiropractor Services

Exams, testing or manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractor Services as specified in the Schedule of Benefits.

Cleft Lip and Cleft Palate

Coverage shall be provided for Inpatient or Outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.

Cancer Clinical Trials

Benefits will be provided for routine costs for Covered Persons who participate in approved cancer clinical trials conducted under the auspices of the following cancer care providers ('cancer care providers'):

- 1. Vermont Cancer Center at Fletcher Allen Health Care;
- 2. The Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center; and
- 3. any Hospital and its affiliated, qualified cancer care providers.

For participation in clinical trials located outside Vermont, coverage under this benefit will be provided only if the Covered Person provides notice to the health benefit plan prior to participation in the clinical trial, and:

- 1. no clinical trial is available at a Vermont or New Hampshire cancer care provider described above;
- 2. the Covered Person has already completed a clinical trial at an approved cancer care provider listed above and that provider has determined that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available at that time under an approved cancer care provider listed above; or
- 3. a. The health plan has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available; and

b. the patient's cancer care provider determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available under an approved cancer care provider listed above.

If a Covered Person participates in a clinical trial administered by a cancer care provider that is not in the health benefit plan's provider network, the health plan may require that routine follow-up care be provided within the health benefit plan's network, unless the cancer care provider determines this would not be in the best interest of the Covered Person.

As used in this benefit, "health benefit plan" means the Policy or any other applicable health benefit plan offered by the Insurer.

Dental Care for an Accidental Injury

Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. No benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

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

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

Benefits are payable as stated in the Schedule of Benefits.

Durable medical equipment

Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose

Hormone Replacement Therapy

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

Human Organ Transplants

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

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

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

- 1. Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.
- Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

- 3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.
- 4. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
 - a. Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery
 - b. Transportation by air ambulance for the donor or the recipient
 - c. Travel time and related expenses required by a Provider
 - d. Drugs that are Investigational
 - e. The cost of acquisition of the organ and any costs incurred by the donor

[Infertility

Covered services related to the diagnosis of infertility shall be same as any other condition.

Covered Services related to the treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer will be provided as shown in the Schedule of Benefits.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- 1. you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and
- 2. you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Special Limitations for Infertility Services

Benefits will not be provided for the following:

- 1. Services rendered to a surrogate mother for purposes of childbirth
- 2. Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures that use a cryo-preserved substance
- 3. Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization or other such body as approved by the Authorized Administrator.]

Infusion Therapy

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

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

Covered Services for Infusion Therapy are as follows:

- 1. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
- 2. All necessary supplies and durable medical equipment including, but not limited to, bandages, cotton swabs, intravenous starter kits, tubing, syringes, needles, pump, pole, and electronic monitor.
- 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, unless treatment is 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.

Medical Foods and Modified Food Products

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products when diagnosed and determined to be Medically Necessary by the Insured Person's Physician, and administered under the direction of a Physician.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry screened in newborn babies.

"Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means an amino acid modified preparation that is intended to be used under direction of a Physician for the dietary treatment of an inherited metabolic disease.

Benefits are provided to the same extent as for any other Illness under the Policy.

Ovarian Cancer Monitoring

Coverage shall be provided for CA-125 monitoring of ovarian cancer subsequent to treatment. This does not apply to routine screenings.

Other Covered Service

- 1. Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture
- 2. Allergy shots and allergy surveys
- 3. Blood and blood components
- 4. Leg, back, arm and neck braces
- 5. Oxygen and its administration
- 6. Medical and surgical dressings, supplies, casts and splints
- Lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with guidelines set forth by the Division of Public Health

Scalp hair prosthesis Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease. Benefits are payable for up to \$500 per {Policy/Calendar} Year

Pregnancy and Maternity Care

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Maternity benefits are **not** available for any Insured Person other than the Insured Participant or the Insured Participant's insured spouse or civil union partner [or domestic partner].

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when our Authorized Administrator determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family

Prosthetic appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

- 1. they are required to replace all or part of an organ or tissue of the human body, or
- 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

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

Sterilization

The Insured Participant's Plan includes benefits for tubal ligation or vasectomy.

Treatment to Bones or Joints in the Face, Neck or Head<8 VSA s 4089g; this mandate covers TMJ and replaces the above provision.> Benefits will be provided for the diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage will be:

- 1. the same as that provided under the Policy for any other musculoskeletal disorder in the body; and
- 2. provided when prescribed or administered by a Physician or a Dentist.

This benefit does not require coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

[Home Health Care

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

Benefits are provided when the Insured Participant or Insured Dependents are confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. A visit is defined as four or fewer hours of services provided by one of the following providers:

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

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

[Hospice Services

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

The Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is 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.

Services and Supplies Provided by a Skilled Nursing Facility

Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

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

Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:

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

Note: No benefits will be provided for:

- 1. Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the number of days as indicated in the Schedule of Benefits.

Hearing Services

[Hearing Services include audiometric exams, hearing aid evaluation test, and limited benefits for hearing aids. See the Schedule of Benefits for maximums, which apply for Hearing Services.]

For Covered Persons who are Dependent Children under age 24, coverage provided for hearing aids up to the amount shown in the Schedule of Benefits.

[Vision Care

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

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

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

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

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

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

Covered Services

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

- 1. Vision Examination
- 2. Single Vision Lenses
- 3. Bifocal Single Lenses
- 4. Bifocal Double Lenses
- 5. Trifocal Lenses
- 6. Lenticular Lenses

- 7. Contact Lenses
- 8. Frames

Special Limitations

Benefits will not be provided for the following:

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

Benefit Payment for Vision Care

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

[Dental Care

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

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

Any expenses incurred beyond the benefit maximum are your responsibility.

Preventative Dental Services

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

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

Primary Dental Services

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

- Fillings
- 2. Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section
- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Endodontics
- 5. Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- 6. Apicoectomies
- 7. Hemisection
- 8. Biopsies of Oral Tissue
- 9. Periodontics/Periodontal Therapy; Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
- 10. Periodontal examination Benefits for periodontal examinations are limited to two per Benefit Period
- 11. Periodontal maintenance procedures Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
- 12. Stainless Steel Crowns
- 13. Repair of Removable Dentures
- 14. Recementing of Crowns, Inlays, Onlays and Bridges
- 15. General Anesthesia/Intravenous Sedation If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation

16. Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

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

Major Dental Services

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

- 1. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- Fixed Bridgework
- 3. Bridge Repairs
- Full and Partial Dentures
- 5. Denture Adjustments, Rebasing and Relining During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

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

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

[Orthodontic Dental Care

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

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

[Up to the age of 19,]Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. The limitations are as follows:

- 1. Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist;
- 2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment

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

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

Special Limitations

No benefits will be provided under this Benefit Section for:

- 1. Dental services which are performed for cosmetic purposes.
- 2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
- 3. Oral Surgery for the following procedures:
 - a. surgical services related to a congenital malformation;
 - b. surgical removal of complete bony impacted teeth;
 - c. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
- 4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
- 5. Hospital and ancillary charges are not covered.
- 6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
- Any services, treatments or supplies included as an eligible benefit under other group hospital, dental, medical and/or surgical coverage.]

[Accidental Death and Dismemberment Benefit

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

Loss Benefit

Loss of life 100% of the Principal Sum

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

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

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

The Principal Sum is stated in the Overview Matrix.

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

[Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Insured Persons in any one Accident or disaster shall not exceed the sum of <\$300,000 - \$500,000>. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed <\$300,000 - \$500,000> the amount of indemnity payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed <\$300,000 - \$500,000>.]

[Repatriation of Remains Benefit

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

If you have minor children who are left unattended as a result of your injury, illness or medical evacuation, our Authorized Administrator will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to your Home Country or Country of Assignment.

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

[Bedside Visit Benefit

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than <3 – 7> days, is likely to be hospitalized for more than <3 – 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 <3 – 7> days or is in critical condition shall be made by the Authorized 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 Authorized 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

1. The following services and supplies are not covered:

Hospitalization, services and supplies that are not Medically Necessary.

No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately
 in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Authorized Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Insurer will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Insurer, either at law or in equity. To initiate your appeal, you must give Insurer written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

Remember, even if your Physician prescribes, orders, recommends, approves or views hospitalization or other health care services and supplies as Medically Necessary, the Insurer will not pay for the hospitalization, services and supplies if its authorized administrator decides they were not Medically Necessary

- 2. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are provided under any Workers' Compensation Law or other similar laws. [This exclusion does not apply to Protection and Indemnity Insurance for Marine crew members.]
- 3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided by a local, state or federal government.
- 4. Services and supplies for any illness or injury occurring on or after your Coverage date as a result of war or act of war (whether declared or

- undeclared), participation in a felony, riot or insurrection.
- Custodial Care Service.
- 6. Routine physical examinations, unless otherwise specified in this Certificate.
- 7. Cosmetic Surgery and related services and supplies, except reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- 8. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- 9. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- 10. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- 11. [Foot care, except for persons diagnosed with diabetes, in connection with corns, calluses, flat fee, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.]
- 12. [Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.]
- 13. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- 14. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- 15. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- 16. Consultations performed by you, your spouse, parents or children.
- 17. [Treatment for hair loss.]
- 18. [Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).]
- 19. [Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.]
- 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. [Contact lenses and glasses unless otherwise specified in this Certificate.]
- 22. [Services and treatment related to elective abortions.]
- 23. [Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate.]
- 24. [Elective Abortions]
- 25. [Dental services unless elected by your Group.]
- 26. [Vision care services unless elected by your Group]
- 27. [Loss arising from [ultra light aircraft], [parasailing], [sail planning], [hang gliding].]

[Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to pregnancy, congenital anomalies of a covered dependent, a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, or Insured Dependents under age 19.

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

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

VII. Prescription Drug Benefits

Introduction and Definitions

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

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

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

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

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

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

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. Call the Insured Person's local Pharmacy or call the toll-free Prescription Benefit Customer Service phone number (x-xxx-xxx-xxxx) for a list of Participating Pharmacies in the Insured Person's area.

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

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

Prescription drugs purchased in Canada, and used in Canada or re-imported legally or purchased through the I-SaveRx program, will be covered on the same benefit terms and conditions as prescription drugs purchased in the U.S.

Conditions of Service

The Drug or medicine must be:

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

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

The Prescription must not exceed a <30 – 180> -day supply.

Reimbursement

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

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

When the Insured Person Goes to a Participating Pharmacy

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

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 3. For injectable, the Insured Person pays as stated in the Schedule of Benefits.

When the Insured Person Goes to a Non-Participating Pharmacy

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

When the Insured Person has his/her Prescription filled at a Non-Participating Pharmacy he/she will be reimbursed at the following rate for each covered Prescription and/or refill after the Insured Person's deductible is satisfied:

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

Claims and Customer Service

Drug claim forms are available at Participating Pharmacies or upon written request to Insurer.

If the Insured Person has any questions about his Prescription Drug Benefit, call the toll-free customer service number: [x-xxx-xxxx.]

Prescription Drug Exclusions and Limitations

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

- 1. Drugs and medications not requiring a Prescription, except insulin.
- 2. Self-administered injectable drugs, except insulin.
- 3. Non-medical substances or items.
- 4. [[Contraceptive Drugs and [certain]] devices prescribed for birth control,] [Drugs and medications used to induce non-spontaneous abortions.]]
- 5. Dietary supplements, cosmetics, health or beauty aids.
- 6. Any vitamin, mineral, herb or botanical product, which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
- 7. Drugs taken while the Eligible Participant are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
- 8. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
- 9. Syringes and/or needles, except those dispensed for use with insulin.
- 10. Durable medical equipment, devices, appliances and supplies.
- 11. Immunizing agents, biological sera, blood, blood products or blood plasma.
- 12. Oxygen.
- 13. Professional charges in connection with administering, injecting or dispensing of Drugs.
- 14. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
- 15. Drugs used for cosmetic purposes.
- 16. Drugs used for sexual stimulation.
- 17. Drugs used for treating hair loss.
- 18. [Drugs used for the primary purpose of treating infertility.]
- 19. Anorexiants or Drugs associated with weight loss.
- 20. Allergy desensitization products, allergy serum.
- 21. All Infusion Therapy is excluded under this Plan except as specifically stated in the Covered Services section.
- 22. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Preexisting Condition, or other contract limitation.
- 23. Growth Hormone Treatment.
- 24. Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
- 25. [The replacement of lost or stolen Prescription Drugs.]
- 26. [Antihistamines.]

VIII. General Provisions

Entire Contract; Changes

The Policy, including this Certificate and any attached endorsements and papers, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of coverage under the Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the Policy.

Grace Period

There is a Grace Period of 31 days allowed for the payment of each premium after the first premium, during which Grace Period coverage under the Policy shall continue in force.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

Third Party Liability

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

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

Coordination of Benefits (COB)

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 Policy Year, and are largely determined by 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;
- 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.
- 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.

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

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

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

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

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

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

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

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:

- 1. It is duly executed on a form acceptable to the Insurer; and
- 2. A copy is on file with the Insurer.

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

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

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

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

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

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

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

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

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

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

The Insurer's right to examine any records that exist:

- 1. During the time the Plan is in force; or
- 2. Until the Insurer pay the last claim.

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

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

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

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

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services.

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS.

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

Review and determination of mental health claims may only be made by a licensed Mental Health Review Agent with the concurrence of a Mental Health Care Professional whose training and expertise is at least comparable to that of the treating clinician.

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:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

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.

Appeal Process

Expedited Claim Appeal

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

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

First Level Appeal

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

Authorized Administrator Address City, State, zip code Telephone number: xxx-xxx-xxxx

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

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

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

Second Level Appeal

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

Authorized Administrator Address City, State, zip code Telephone number: xxx-xxx-xxxx

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

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

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

Independent External Review

When a Covered Person has exhausted all applicable internal review procedures provided by the Insurer, such Covered Person will have the right to an independent external review of any decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review will be available when requested in writing by the affected insured, provided the decision to be reviewed requires the Insurer to expend at least \$100.00 for the service and the decision by the plan is based on one of the following reasons:

1. The health care service is a covered benefit that the health insurer has determined to be not medically necessary.

- 2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and rules.
- 3. The health care treatment has been determined to be experimental, investigational or an off-label drug. A health benefit plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal, and shall decide such appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the commissioner.
- 4. The health care service involves a medically-based decision that a condition is preexisting.

The right to an independent review will not be construed to change the terms of coverage under the Policy.

The independent external reviews will be conducted:

- 1. By independent review organizations pursuant to a contract with the department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section; and
- 2. In accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

The Covered Person will:

- 1. be provided with adequate notice of their review rights under this section;
- 2. have the right to use outside assistance during the review process and to submit evidence relating to the health care service;
- 3. pay an application fee of \$25.00 for each request for an independent external review of an appealable decision not to exceed a total of \$75.00 annually. The application fee may be waived or reduced based on a determination by the Commissioner of Insurance that the financial circumstances of the Covered Person warrants a waiver or reduction. The application fee will be paid by the Insurer, not the Covered Person, if the independent review organization reverses the Insurer's decision to deny payment for a health care service; and
- 4. Be protected from retaliation for exercising their right to an independent external review.

Other costs of the independent review will be paid by the Insurer.

The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan.

The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable state or federal laws.

The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure in accordance with Vermont law.

Decisions relating to the following health care services shall not be reviewed under this section, but shall be reviewed by the review process provided by law:

- 1. Health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan.
- 2. Health care services provided to inmates by the Department of Corrections.

Date:

May 25, 2011

To:

State Insurance Departments

From:

Linda Hickok, Vice President, Compliance

Subject:

Filing Authority for Coulter & Associates, Inc.

4 Ever Life Insurance Company has authorized Coulter and Associates, Inc., acting as its Contracts and Actuarial Consultants, to file products, develop and file rates, and correspond with your Department on our behalf.

| Signature: | Lunda H Thibal | |
|------------|----------------|--|
| | | |

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

☐ INDIVIDUAL HEALTH BENEFIT PLANS (Complete <u>SECTION A</u> only)

| | SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete <u>SECTION B</u> only) | | | | | |
|--|--|---|---|--|--|--|
| requirements of the Patient P coverage referred to as "major includes the requirements for the relevant statute to ensure | rotection and Affordable Car or medical" in the statute, wh grandfathered (coverage in compliance. Complete each | with your [endorsement][contractive Act (PPACA). These PPACA ich is comprehensive health coverffect prior to March 23, 2010) a litem to confirm that diligent contact satisfy the requirement and ich | requirements apply only to polerage that includes PPO and Hand non-grandfathered plans, are sideration has been given to ea | MO coverage. This form and relevant statutes. Refer to ch. (If submitting your filings | | |
| *For all filings, include the | Type of Insurance (TOI) in | the first column. | | | | |
| Check box if this is a paper | filing. | | | | | |
| | | COMPANY INFORMATION | | | | |
| Company Name | NAIC Number | SERFF Tracking Number(s) *if applicable | Form Number(s) of Policy being endorsed | Rate Impact | | |
| | | | | ☐ Yes ☐ No | | |

| | SECTION A – Indi | vidual Health Benefit Plans | | |
|-----|--|--|-----------------------------------|--------------------------------------|
| TOI | Category | Statute Section | Grandfathered | Non- Grandfathered |
| | | | | |
| | Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19 | [Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA] | N/A | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014. | [Section 2711 of the PHSA/Section 1001 of the PPACA] | N/A | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Eliminate Lifetime Dollar Limits on Essential Benefits | [Section 2711 of the PHSA/Section 1001 of the PPACA] | ☐ Yes ☐ No If no, please explain. | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | _ | |
| | Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact. | [Section 2712 of the PHSA/Section 1001 of PPACA] | ☐ Yes ☐ No If no, please explain. | Yes No If no , please explain |
| | Explanation: | ' | | |
| | Page Number: | | | |

| | SECTION A – Indi | vidual Health Benefit Plans | | |
|-----|--|--|-----------------------------------|---|
| TOI | Category | Statute Section | Grandfathered | Non- Grandfathered |
| | Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services. Explanation: Page Number: | [Section 2713 of the PHSA/Section 1001 of the PPACA] | N/A | Yes No If no , please explain. |
| | Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. Explanation: Page Number: | [Section 2714 of the PHSA/Section 1001 of the PPACA] | ☐ Yes ☐ No If no, please explain. | ☐ Yes ☐ No If no, please explain. |
| | Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number: | [Section 2719 of the PHSA/Section 1001 of the PPACA] | N/A | ☐ Yes ☐ No If no , please explain. |
| | Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level. Explanation: Page Number: | [Section 2719A of the PHSA/Section 10101 of the PPACA] | N/A | ☐ Yes ☐ No If no, please explain. |

| | SECTION A – Indi | | | |
|-----|---|--|-----------------------|---------------------------------------|
| TOI | Category | Grandfathered | Non- Grandfathered | |
| | Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network. | [Section 2719A of the PHSA/Section 10101 of the PPACA] | N/A | Yes No If no , please explain. |
| | Explanation: Page Number: | | | |
| | Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology. | [Section 2719A of the PHSA/Section 10101 of the PPACA] | N/A | Yes No If no , please explain. |
| | Explanation: | | | |
| | Page Number: | | | |

| | SECTION B – Group Heal | th Benefit Plans (Small and La | arge) | |
|-----|--|---|---|-------------------------------|
| TOI | Category | Statute Section | Grandfathered | Non- Grandfathered |
| | | | | |
| | Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19 | [Sections 2704 of the PHSA/Section 1201 of the PPACA] | Yes No If no , please explain. | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014. | [Section 2711 of the PHSA/Section 1001 of the PPACA] | ☐ Yes ☐ No If no , please explain. | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Eliminate Lifetime Dollar Limits on Essential Benefits | [Section 2711 of the PHSA/Section 1001 of the PPACA] | ☐ Yes ☐ No If no, please explain. | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact. | [Section 2712 of the PHSA/Section 1001 of PPACA] | ☐ Yes ☐ No If no, please explain. | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |

| | SECTION B – Group Heal | arge) | | |
|-----|--|--|---|-------------------------------|
| TOI | Category | Statute Section | Grandfathered | Non- Grandfathered |
| | | | | |
| | Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services | [Section 2713 of the PHSA/Section 1001 of the PPACA] | N/A | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊ | [Section 2714 of the PHSA/Section 1001 of the PPACA] | ☐ Yes [⋄] ☐ No If no , please explain. | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |
| | Appeals Process – Requires establishment of an internal claims appeal process and external review process. | [Section 2719 of the PHSA/Section 1001 of the PPACA] | N/A | Yes No If no, please explain. |
| | Explanation: | | | |
| | Page Number: | | | |

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

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

Responses to 20120213 VT Objections

(1) Thank you for providing the required eligible group compliance certification, however, although Assistant Vice President Linda Hickok's certification identifies 8 VSA § 4079(1) employer-employee groups as the SOLE target market for this product, the SERFF General Information submission text identifies 8 VSA § 3803 (i.e., the life & annuity statute under Chapter 103 of Title 8 rather than the accident and health (A&H) statute under Chapter 107) as the target market groups. Please clarify.

RESPONSE: The reference to 8 VSA § 3803 in the Filing Description was incorrect. It should have read 8 VSA § 4079(1). Please see the attached revised certification.

(2) PPACA/ACA does not currently, at this time, apply to large group MM products. Is it the insurer's intent to revise this MM product now, for compliance with PPACA/ACA requirements? \

RESPONSE: To our knowledge, this product now complies with PPACA. Any changes required later on will be complied with at the appropriate time.

(3) While this product is clearly intended to be MM insurance, the SERFF submission text identifies this as a "hospital/medical/surgical" product, which is an entirely different animal altogether [Regulation 80-1]. Please clarify.

RESPONSE: What text are you referring to? The TOI clearly identifies this as a MM product. The reference to "hospital/medical/surgical" is in the Filing Description where we are attempting to explain the types of benefits being provided.

(4) The SERFF submission text also states that under this MM product "There is no network and no network differential for providers outside the United States. A Blue Cross/Blue Shield PPO network is used when a person is state side." Please identify the Blue Cross Blue Shield (BCBS) entity or entities with whom the insurer has contracted to provide coverage for persons while in the USA.

RESPONSE: 4 Ever Life is licensed by the Blue Cross Blue Shield Association as a licensee of the association. As a licensee, products produced under this license, branded with the Blue Cross/Blue Shield logo, have access to the network on a national scale through the BlueCare program. Member's seeking service within Vermont have access to the same network as BlueCross Blue Shield of Vermont.

(5) The SERFF submission text and certain policy provisions seem to indicate that, in addition to employer-employee groups, the insurer also intends to market this product to "multiple employer trust" (METs) groups. For example, the insurer's "project name" for this product filing is "MET Group Major Medical – Outbound." As you know, single-employer products are very different from multiple-employer products and in some instances are subject to completely different regulatory requirements. Please clarify.

RESPONSE: This product was originally designed for use with an MET. This purpose was changed and in Vermont it is the Company's intend to issue a policy to individual employers only.

(6) Please revise Assistant Vice President Linda Hickok's compliance certification to explicitly certify compliance with federal PPACA/ACA requirements.

RESPONSE: The revised certification is attached. Revised certification attached.

(7) Your submission text asserts that all of the Department's comments on the BCS Insurance Company's "companion" filing (VFN 54559 – see copy of disapproval report attached) have already been addressed in this more recent filing. Please confirm.

RESPONSE: At the time of submission all fixes that related to known objections to the BCS plan we incorporated into this 4 Ever Life plan. Anything that was raised subsequent to the submission of this 4 Ever Life plan would not have been accounted for.

(8) The "product name" for this product is filed as variable. Why is that?

RESPONSE: The "Product Name" is bracketed because it will change from group to group. For example, if the policyholder is the ABC Corporation, the product name might include "ABC Corporation" in it. Accordingly, if the XYZ Company is the policyholder, the reference will be to the "XYZ Company Group Plan."

(9) The group policy identifies the product it describes as the "HTH Group Insurance Plan." What does that mean? For example, is "HTH" the name of a purchaser company (employer?) and therefore these forms are being filed on a one case basis rather than for general use? Please clarify.

RESPONSE: The reference to HTH, which is found in the certificate, was an error and we have deleted it.

(10) This managed care product's "service area" is (a) filed as 100% variable and (b) described as "{within the United States/outside the United States/anywhere in the world}." Please explain (c) the factors or circumstances that dictate what the service area will be, and (d) whether or not the service area, once designated under an issued policy, can be changed.

RESPONSE: The policyholder determines the service area. In most cases the Company anticipate the policyholder selecting "worldwide" so member's have options when they come back to the United States or when visiting. In a few cases, the policyholder will select "outside the United States." The most common reason for this is that they keep their domestic coverage, which may be restrictive or very limited outside of the United States, and use this coverage for when the employee is outside the U.S. There is little or no market for "inside the United States only." Accordingly, we have deleted this option.

(11) Why are multiple types of brackets used to identify substantive text filed as variable (e.g., both "hard" [XXX] and "soft" {XXX} brackets) and what is the significance of bold typeface brackets versus non-bold typeface brackets?

RESPONSE: The different brackets mean slightly different things. For example, hard [brackets] means that the text between the brackets may be included or excluded. Text separated by a / (forward slash) and bracketed by soft {brackets} means that the policyholder may choose among the options presented.

(12) This two-page "wrap around" policy form contemplates policy administration being performed by a "third party administrator" or TPA. Please (a) verify that this policy will always be administered by a TPA, (b) provide a complete list of TPAs with which the insurer has contracted for the purpose of administering this or similar policies, (c) confirm that the TPA and the insurer and the contractual relationship between the two always, at all times and in all instances, complies with the Department's "VHCURES" regulation [Regulation H-2008-01] and (d) revise Ms. Hickok's compliance certification to explicitly certify compliance with the VHCURES regulation.

RESPONSE: (a) The policy will always be administered by a licensed Third Party Administrator. (b) The plan will use only one TPA, Worldwide Insurance Services, Inc., which is registered with Vermont. (c) Worldwide Insurance Services and 4 Ever Life will comply with VHCURES regulations. (d) A revised compliance certificate is attached under the Supporting Documentation tab.

(13) Is (a) the policy's "incorporation" clause on policy page 2 intended to constitute the mandated "entire contract" provision? [8 VSA § 4065(2), Regulation 80-1 § 3] or (b) is the "agreement" clause on policy page 1 intended to comply with the "entire contract" mandate? Please (c) note that the definition of what constitutes the "entire" contract differs between the two provisions described under (a) and (b) above (for example, one includes "riders and endorsements" in the definition of what constitutes the entire contract, the other does not), (d) provide the VFNs, approval dates and FYI-only copies of ALL of the "endorsements and riders" mentioned in the "incorporation provision" on policy page 2 that the insurer anticipates using to modify this product or that can or might or could be used by the insurer to modify this product, and (e) note that, by law, insurance contracts MUST include an "entire contract" clause [8 VSA § 4065(1), Regulation 80-1 § 3] regardless of the "incorporation" and "agreement" clauses. Please revise accordingly.

RESPONSE: The policy's "Incorporation Provision" simply means that the items attached to the policy, including a copy of the certificate, are incorporated into and are a part of the policy. The Entire Contract and Changes provision is found on page 43 of the certificate, which, as previously mentioned, will be incorporated as a part of the policy at the time of issue.

(14) Please provide the VFN, approval date and an FYI-only copy of the Vermont civil unions rider that is always issued with this product.

RESPONSE: This is a new product and has never before been issued in Vermont. We incorporated the Civil Union requirements into the forms and did not think a separate rider was necessary. Are you saying that we still need to use this rider even though the requirements have been incorporated? Please advise.

(15) The group policy cover page includes a "policy term" item; is this product sold as a so-called "limited term" product rather than an auto-annual-renewal "evergreen" policy?

RESPONSE: This policy is an auto-annual-renewal "evergreen" policy.

(16) All group policies, even the "wrap around" versions, must include all of the standard "boilerplate" provisions required by 8 VSA § 4065 and Regulation 80-1, however this policy form fails to include the majority of those provisions. Please revise accordingly.

RESPONSE: The boilerplate provisions have been added to the policy as you have requested; they now appear in both the policy and the certificate.

SERFF Tracking #: BCSF-127963460 State Tracking #: 58065 Company Tracking #: MET 54.1201 VT

State: Vermont Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical

Project Name/Number: MET Group Major Medical - Outbound/MET 54.1201 VT F

Superseded Schedule Items

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

| | Schedule Item | | | Replacement | |
|---------------|---------------|------------------------|---------------------------------|----------------------|---|
| Creation Date | Status | Schedule | Schedule Item Name | Creation Date | Attached Document(s) |
| 01/06/2012 | | Form | Group Policy | 04/19/2012 | Form 54.1201 ER VT - Policy (20120105 cc).pdf (Superceded) |
| 01/06/2012 | | Form | Certificate of Coverage | 04/19/2012 | Form Number 54.1301 ER VT - Cert (20120105 cc).pdf (Superceded) |
| 01/06/2012 | | Supporting Document | Filing Compliance Certification | 04/19/2012 | VT Certification of Compliance.pdf (Superceded) |
| 01/06/2012 | | Supporting Document | Health Filing Data | 04/19/2012 | Form 54.1201 ER VT (20120105 SOV).pdf (Superceded) Form Number 54.1301 ER VT (20120105 SOV).pdf (Superceded) |
| 01/06/2012 | | Supporting Document | Redlined Copy | 04/19/2012 | |

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200

2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

[Product Name] MAJOR MEDICAL EXPENSE INSURANCE

POLICYHOLDER: [Employer]

POLICY EFFECTIVE DATE: [Month, Date, Year]

POLICY NUMBER: <###> ("the Policy")

STATE OF DELIVERY: Vermont

ADMINISTRATOR: [Authorized Administrator]

This Policy is a legal contract between the Policyholder and 4 Ever Life Insurance Company (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGRFFMFNT

This Policy, the Certificates issued under the policy, the application(s) of the Policyholder form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by an Insured Person, by the Insurer's Agent, or by any other person are not part of this Policy. Only the Insurer's President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Insured Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date.

POLICY TERM

Policy Effective Date: <MM/DD/YYYY>
Policy End Date: <MM/DD/YYYY>

Policy Termination Date: The Policy will continue in force for the while the required premiums are paid until the Policy End Date or the Policy is terminated by either the Policyholder or by the Insurer. At least <45 – 90> days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Group's coverage under the Policy may be cancelled at any time after <45 – 90> days written notice mailed or delivered by the Insurer to the Group or by the Group to the Insurer.

If the Insurer cancels the coverage under the Policy, the Insurer will mail or deliver the written notice to the Group at the last address stated in the Insurer's records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the <45th -91sl > day after the Insurer mails or delivers the written notice.

If the Group cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Insured Person's period of coverage. No benefit is payable for charges incurred after the effective date of cancellation of coverage under the Policy, except as provided in the Policy's benefit provisions.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Form 54.1201 ER VT

Cancellation of Insured Person's Coverage: An Insured Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.

Cancellation of Insured Person's Coverage: An Insured Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. local time on the date stated in the written notice or, if later, 11:59:59 p.m. local time on the date the Insurer receives the written notice.

Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly, semi-annually, annually, or for a specified term less than one year. Coverage will terminate if the required premium is not paid to the Insurer, subject to the Grace Period. Premium is charged from the date insurance for each Insured Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Premium Due Dates: The Insured Person's first premium is due and payable on the Insured Person's Effective Date of Coverage.

Change in Premium: The Insurer may change the premiums due on or after the first Policy Anniversary Date. The Insurer shall give written notice of such change at least 60 days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended. If the Insurer changes rates, the change will apply only to coverage starting on or after the effective date of the change. The Insurer will give the Policyholder at least 31 days advance written notice of any change.

INDIVIDUAL CERTIFICATES

The Insurer will furnish to the Policyholder, for delivery to each Eligible Participant, an individual certificate setting forth in substance the essential features of the insurance coverage of such Eligible Participants and to whom benefits thereunder are payable.

NEW MEMBERS

New Members: Eligible new employees and dependents may be added to the Group Policy, in accordance with the terms of the Policy and the attached Certificate.

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of 4 Ever Life Insurance Company.

HFBLackam, II

GROUP INSURANCE POLICY
PROVIDING ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable

Form 54.1201 ER VT

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: [c/o Authorized Administrator, Address 1, Address 2, City/State/Zip]

[Product Name] HTH Group Insurance Plan

[<\$0 - \$10,000> Deductible Plan] Major Medical Plan

Certificate of Coverage Number: Effective Date:

This Plan is a Participating Provider Plan for major medical care.

Under this Plan, 4 Ever Life Insurance Company (Insurer) pays certain benefits at higher payment percentages when the services of a Participating Provider are used.

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit when it is in connection with a Medical Emergency.

The Insurance Coverage Area is any place that is {within the United States / outside the United States / anywhere in the world}.

Table of Contents

HFBLackam, II

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I. Introduction

About This Plan

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

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

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

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

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

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 [Authorized Administrator Name] as its administrator.

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. [Authorized Administrator Name] provides a list to Eligible Participants of Foreign Country Providers with whom [Authorized Administrator Name] 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 [Authorized Administrator Name] is able to provide background information and to arrange access for Insured Persons.

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

[Authorized Administrator/4 Ever Life Insurance Company] has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services inside the United States, Puerto Rico, or the United States Virgin Islands, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between [Authorized Administrator/4 Ever Life Insurance Company] and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care inside the United States, Puerto Rico, and the United States Virgin Islands, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). In some instances, you may obtain care from providers that do not contract with the Host Blue (non-participating healthcare providers). [Authorized Administrator/4 Ever Life Insurance Company's] payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, [Authorized Administrator/4 Ever Life Insurance Company] will remain responsible for fulfilling [Authorized Administrator/4 Ever Life Insurance Company] contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to [Authorized Administrator/4 Ever Life Insurance Company].

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

discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price [Authorized Administrator/4 Ever Life Insurance Company] use[s] for your claim because they will not be applied retroactively to claims already paid.

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

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

1. Member Liability Calculation

When covered healthcare services are provided inside the United States, Puerto Rico, or the United States Virgin Islands by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment [Authorized Administrator/4 Ever Life Insurance Company] will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, [Authorized Administrator/4 Ever Life Insurance Company]may use other payment bases, such as billed covered charges, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount [we/Licensee Name] will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment [Authorized Administrator/4 Ever Life Insurance Company] will make for the covered services as set forth in this paragraph.]

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.

OVERVIEW MATRIX

| | Limits Outside the U.S. | [Limits In Network, U.S.] | [Limits Out-of-Network, U.S.] | |
|--|--|--|--|--|
| MEDICAL EXPENSES | | | | |
| Deductible Any deductible paid for one column will be applied towards the deductible in another column. | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$10,000> per Insured Person per {Policy/Calendar} Year [and limited to <\$0 - \$25,000> per Family per {Policy/Calendar} Year] | |
| Payment Level One | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75 - 100%> of the Usual and Customary Fee.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75 - 100%> of the Negotiated Rate.] | [[Until the Coinsurance Maximum is satisfied,] the Insurer will pay <75-100%> of the Usual and Customary Fee.] | |
| Payment Level Two | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | |
| Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the deductible in another column. | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | [<\$0 - \$50,000> per Insured Person per {Policy/Calendar} Year and limited to <\$0 - \$125,000> per Family per {Policy/Calendar} Year] | |
| [ACCIDENTAL DEATH AND DISMEMBERMENT | Maximum Be | enefit: Principal Sum up to <\$10,000 | - \$100,000>] | |
| [REPATRIATION OF REMAINS | Max | kimum Benefit up to <\$10,000 - \$50,00 | 00>] | |
| [MEDICAL EVACUATION | Maximum Lifetime Benefit for all Evacuations up to <\$50,000 - \$1,000,000>] | | | |
| [BEDSIDE VISIT | | 00 - \$10,000> for the cost of one econo ns in, the place of the Hospital Confine | | |

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

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] |
|---|--|--|---|
| Preventive Care Services – Deduct | ible is not applicable | | |
| For Dependent Children (Birth to Age 19) | 100% of the Usual and Customary Fee | 100% of the Negotiated Rate | {All except a <\$0 - \$100> Copayment / (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| For Adults (Age 20 and Older) | 100% of the Usual and Customary Fee | 100% of the Negotiated Rate | {All except a <\$0 - \$100> Copayment / (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Services Provided by a Physician of applicable] | or Provider – Copayments [[and Ded | uctible apply] if applicable unless sp | ecifically stated /Deductible is not |
| Physician Office Visits | [Deductible does not apply] [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [Deductible does not apply] [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [Deductible does not apply] [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Surgical Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Medical Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Emergency Care | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| Other Physician services | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)} |
| [Annual Physical Examination/Health screening for services not covered by Preventative Care] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year. | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}up to a Maximum of <\$500 - \$1,000> and limited to one per {Policy/Calendar} Year.] |
| [Travel Vaccinations/Immunizations not covered under Preventative Care Services] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year.] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] | [{After a <\$0 - \$100> Copayment][, (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here)}[up to a Maximum of <\$200 - \$500> per {Policy/Calendar} Year] |
| Services and Supplies Provided by | a Hospital – Copayments and Dedu | ctible apply if applicable, unless spe | cifically stated |
| Inpatient Hospital Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |
| Outpatient Hospital Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) |

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | |
|--|--|--|--|--|
| Emergency Care ¹ | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Other Services and Special Conditions – Copayments [[and Deductible apply] if applicable, unless specifically stated | | | | |
| Ambulance Transportation | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Ambulatory Surgical Facility | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Autism Spectrum Disorders | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Dental Care for an Accidental Injury | Same as any Injury / <50% - 100%> of Covered Expenses up to <\$50 – \$1,000> per Policy Year maximum [and limited to <\$50 – 200> per tooth] | | | |
| Maternity | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Mental Illnesses | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Chiropractic Care | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year | [Deductible does not apply] {After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 - 50> visits per {Policy/Calendar} Year [| |
| Physical/Occupational/Speech Therapy/Medicine and Other Specified Therapies | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | [Deductible does not apply] [{After a <\$0 - \$100> Copayment] (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here, and as many as <6 – 50> visits per {Policy/Calendar} Year. | |
| Infusion Therapy/Radiation Therapy/Chemotherapy | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| Human Organ Transplants | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here) | |
| [Infertility Treatment | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime | Limited to <\$25,000 - \$100,000> per lifetime] | |
| Home Health Care | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | |
| Skilled Nursing Facilities | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here), [up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year] | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted here),[up to a maximum of <10 – 180> visits per {Policy/Calendar} Year]] | |
| Hospice | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | (Overview Matrix, [Payment Level 1][and Payment Level 2] inserted | |

| Benefits | Outside the U.S. | [In Network, U.S.] | [Out-of-Network, U.S.] | |
|---|--|--------------------|------------------------|--|
| | here) | here) | here) | |
| Pharmacy Benefits | | | | |
| Pharmacy – Outside the US Maximum <30 – 180> day supply | {<50% - 100%> of actual charge / the Copayment stated below} | | | |
| Prescription Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | |
| 2. Injectables | All except a <10% - 30% Copayment per Prescription, per 30 day supply] | | | |
| Pharmacy – Inside the US Maximum <30 – 180> day supply | {<50% - 100%> of actual charge / the Copayment stated below} | | | |
| Generic Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | |
| 2. Brand name Drugs | All except a <\$5 - \$30> Copayment per prescription, per 30 day supply | | | |
| 3. Injectables | All except a <10% - 30% Copayment per Prescription, per 30 day supply] | | | |
| Hearing Services | No Deductible. <50% - 100%> of Covered Expenses per Policy Year up to a maximum of \$500 for Hearing Services that are not the result of an Injury or Illness. In addition, for a Covered Person who is a Dependent Child under age 24, 100% of Covered Expenses up to a maximum of \$1,000 per Hearing Aid every three years. | | | |
| [Vision Care | No Deductible. <50% - 100%> of Covered Expenses per Policy Year up to a maximum of <\$250 -\$1,000> for Vision Care that is not the result of an Injury or Illness.] | | | |
| [Dental Care | Subject to a maximum Covered Expenses of <\$500 - \$3,000> per {Policy/Calendar} Year. | | | |
| Preventive Dental Services | 100% of Actual Cost | | | |
| 2. Primary Dental Services | <100% - 50%> of Actual Cost | | | |
| Major Dental Services | <100% - 50%> of Actual Cost [Major Dental Services are not covered during the first <3 - 6> months the Insured Person is insured.] | | | |
| [Orthodontic Dental Care | No Deductible. 50% of Actual Cost up to a Lifetime Maximum of <\$500 - \$3,000> [Orthodontic expenses are not covered during the first <3 – 6> months the Insured Person is insured.] | | | |

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

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], [employee], 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 Employee

An Eligible Employee means a permanent full time employee or trainee, who usually works at least <20 – 40> hours a week in the conduct of the Group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis. [An Eligible Employee does not include an employee who works on a part-time, temporary, or substitute basis.] [An Eligible Employee may be a consultant or contractor engaged by the Group in the conduct of its business and works in the conduct of the Group's business at least <20 – 40> hours a week.] [An Eligible Employee also includes officers and directors of the Group regardless of the number of hours a week devoted to the conduct of the Group's business.] [An Eligible employee resides outside his/her Home Country and is scheduled to reside outside his/her Home Country for a period greater than <3 – 24> months.]

[If two members of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Group, then each must enroll separately as an Insured Participant.]

[Eligible Dependents

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

- 1. Spouse, or civil union partner, [or domestic partner]:
- 2. natural child, stepchild or legally adopted child and includes a dependent of a civil union [or domestic partnership] who has not yet reached age 26;
- 3. own or spouse's or civil union partner's or domestic partner'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 or spouse/partner. 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. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.]

[As used above:

- 1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
- 2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
- 3. The term "domestic partner" means a person of the same or opposite sex who:
 - a. is not married or legally separated;
 - b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
 - is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months:
 - d. occupies the same residence as the Eligible Participant;
 - e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
 - f. as entered into a domestic partnership arrangement with the named Insured.
- 4. The term "domestic partnership arrangement means the Eligible Participant and another person of the same or opposite sex has any three of the following in common:
 - a. joint lease, mortgage or deed;
 - b. joint ownership of a vehicle;
 - c. joint ownership of a checking account or credit account;
 - d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
 - e. designation of the domestic partner as a beneficiary of the employee's will;
 - f. designation of the domestic partner as holding power of attorney for health care; or
 - a. shared household expenses.
- 5. The term "civil union partner" means a person with whom the Eligible Participant has entered into a civil union in accordance with Vermont law.
- 6. The term "civil union" means that two eligible persons have established a relationship pursuant to Vermont Statute, Title 15, Chapter 23 and are thereby entitled to receive the benefits and protections and be subject to the responsibilities of spouses.]

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. [Citizen of the U.S. or permanent resident of the U.S. (as defined by the immigration code of the U.S.)]
- 2. [Employed by a company with offices in the U.S.]
- 3. [not a resident of the U.S.]
- 4. [his/her Home Country is not the U.S.]
- 5. [under Age <60 85>].
- 6. [Country of Assignment is other than the Eligible Participant's Home Country.]

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. [Applications will be accepted up to 30 days after the Initial Eligibility Date, however,] 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. <u>Newborn Children:</u> 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. <u>Court Ordered Coverage for a Dependent:</u> If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is a spouse or civil union partner [or domestic partner] 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. <u>Adopted Children:</u> 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.

[Special Enrollment Periods

- Eligible Participants who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they have other coverage may do so within 31 days after that other coverage terminates if the following requirements are met:
 - a. If the other coverage was COBRA continuation under another plan, that continuation must have been exhausted before the Eligible Participant may enroll the affected persons under this Plan.
 - b. If the other coverage was not COBRA continuation, then any employer contribution toward the cost of the coverage must have terminated or that coverage must itself have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:

- legal separation or divorce;
- ii. death:
- ii. termination of employment or reduction in hours of employment.

The Eligible Participant must have declined enrollment for employee and/or dependent coverage during the Initial Enrollment Period by means of a written statement that the reason for declining enrollment was other coverage.

- 2. An Eligible Participant who did not enroll during the Initial Enrollment Period may enroll for participant and/or dependent coverage within 31 days after he or she marries or acquires an Eligible Dependent Child or Children by birth, adoption, or placement for adoption.
- 3. An Eligible Participant who did not enroll his or her spouse or civil union partner [or domestic partner] during an Initial Enrollment Period may enroll that spouse or civil union partner [or domestic partner] within 31 days after the Eligible Participant acquires an Eligible Dependent Child or Children by birth or adoption or placement for adoption.

If an Eligible Participant does not apply within the 31 days of the Initial Enrollment Period or within the 31 days of a Special Enrollment Period as outlined above, he/she will become a Late Enrollee.]

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;
- 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 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:

- the date the Insured Participant's Insured Dependent no longer meets the definition of an Eligible Dependent as defined in the Planthe end of the
 period for which premium payment has been made to the Insurer;
- 2. the date the Policy terminates;
- 3. the date the Insured Participant's coverage terminates;
- 4. 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.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits" provisions of this Certificate or as specified below when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

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;
- on any premium due date for any of the following reasons. The Insurer must give the Group written notice of at least 30 days in advance if termination is due to:
 - a. failure to maintain the required minimum premium contribution;

- b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
- c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.
- 4. on any premium due date if the Insurer is also canceling all Group Health Benefit Plans in the state or in a geographic Service Area. The Insurer must give the Group written notice of cancellation:
 - a. at least 180 days in advance; and
 - b. again at least 30 days in advance.

Extension of Benefits

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

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

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

[Continuation (COBRA)

Most employers in the United States who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law, which governs this provision the Insured Participant may also be entitled to a period of continuation of coverage under this Act. The Insured Participant should check with his/her employer for details.]

III. Definitions

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

Accidental Injury means an accidental bodily Injury sustained by an Insured Person, which is the direct cause of a loss and which is not the result of disease or bodily infirmity.

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

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

Age means the Insured Person's attained age.

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

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

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

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

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

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Autism Services Provider means any licensed or certified person providing treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder and Asperger's disorder.

Diagnosis of Autism Spectrum Disorders means medically necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other testing to determine whether an individual has one or more Autism Spectrum Disorders. For purposes of this definition, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a licensed Physician or by Psychologist if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing.

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

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

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

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

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

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

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs. Includes medically-necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Chiropractor means a duly licensed chiropractor.

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

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider.

Claim Payment means the benefit payment calculated by the Insurer, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider.

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

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulates the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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 {Policy/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 or are caused by pregnancy, isuch as acute nephritis, nephrosis, cardiac decompression, missed abortion, 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 false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

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

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

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

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. Reconstructive Surgery is surgery to correct the appearance of abnormal

looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons**.

Country of Assignment means the country for which the Eligible Participant has a valid 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.

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

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

Covered Person means the Insured, and any Eligible Dependents.

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

Creditable Coverage means coverage you had under any of the following:

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

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

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

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

Dentist means a duly licensed dentist.

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

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

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

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

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

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

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

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

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

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

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

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

Emergency (See Emergency Medical Care)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Habilitative Care or Rehabilitative Care means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals the provider has identified.

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

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

Home Health Agencies and Visiting Nurse Associations are home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Eligible Participant's home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations, or the local/national authority if outside the United States.

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, or the local/national authority if outside the United States.

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 or the local/national authority if outside the United States.

Hospital means any establishment that is licensed in the country where it operates and where the medical practitioner permanently supervises the patient. The following establishments are not considered as hospitals: rest and nursing homes, spas, cure-centers, and health resorts.

An **Illness** is a sickness or disease of an Insured Person, which first manifests itself after the Insured Person's Effective Date and while coverage is in force.

Individual Coverage means coverage under this Certificate for yourself but not your spouse or civil union partner [or domestic partner].and/or eligible dependent children.

Infertility means the condition of an otherwise presumably healthy individual who is unable to conceive or produce conception during a period of one year.

Infusion Therapy is the administration of Drugs (prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

Initial Eligibility Date is the Effective Date for a participant who becomes eligible after the Effective Date of the Policy.

Initial Enrollment Period is the 31 day period during which an Eligible 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)

Inpatient means that you are a registered bed patient and are treated as such in a health care facility.

Insurance Coverage Area is the primary geographical region in which coverage is provided to the Insured Person.

Insured Dependents are members of the Eligible Participant's family who are eligible and have been accepted by the Insurer under this Plan.

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Plan. Insured Participant is also referred to as 'you'.

Insured Person means both the Insured Participant and all other Insured Dependents who are covered under this Plan.

The Insurer means 4 Ever Life Insurance Company that is a nationally licensed and regulated insurance company.

Investigative Procedures (See Experimental/Investigational).

Investigational or Investigational Services and Supplies means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the appropriate government agency at the time used or administered to you.

A Late Enrollee means any Eligible Participant or Eligible Dependent who submits his/her written application after the expiration of the Initial Enrollment Period or the Special Enrollment Period.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maternity Service means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy that, through vaginal delivery, results in an infant, who weighs *5* pounds or more.

Maximum Allowance means the amount determined by a Plan that Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers in the United States of America will be based on the Schedule of Maximum Allowances. A Plan may amend these amounts from time to time.

Medical care means:

- 1. The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
- 2. Transportation primarily for and essential to medical care referred to in Paragraph (1).

Medically Necessary (See exclusions section of this certificate)

Mental Health Care Professional means any person, corporation, facility or institution certified or licensed by this state to provide mental health care services, including but not limited to a physician, a nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such provider acting in the course and scope of employment or an agency related to mental health care services.

Mental Health Review Agent means a person or entity performing service review activities who is either affiliated with, under contract with, or acting on behalf of a business entity in the state of Vermont; or a third party who provides or administers mental health care benefits to citizens of Vermont, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care Physicians to coordinate delivery of services, authorized to offer health insurance policies or contracts in Vermont.

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient, or as approved by the Authorized Administrator. Mental Illness will also include Substance Abuse and the following biologically-based mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- schizophrenia;
- 2. bipolar disorder:
- obsessive-compulsive disorder;
- major depressive disorder;
- 5. panic disorder;
- 6. anorexia nervosa;
- 7. bulimia nervosa;
- 8. schizo-affective disorder; and
- 9. delusional disorder.

Negotiated Rate is the rate of payment that the Insurer has negotiated with a Participating Provider for Covered Services.

Network means the group of participating providers providing services to a managed care plan

A **Newborn** is a recently born infant within 31 days of birth.

Non-Participating Hospital (out of network) is a Hospital that has not entered into a Participating Hospital agreement with the Insurer at the time services are rendered.

A Non-Participating Physician (out of network) is a Physician who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-Participating Provider (out of network) is a provider who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-U.S. Resident means an expatriate who is a U.S. Citizen or third country national residing outside of the United States.

Nursing at Home means physician prescribed Skilled Nursing Service at your residence immediately after or instead of inpatient or outpatient care treatment.

Nursing at Home Care Program means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on

an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Occupational Therapist means a duly licensed occupational therapist.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

- 1. History (gathering of information on an Illness or Injury).
- Examination.
- 3. Medical Decision Making (the Physician's diagnosis and Plan of treatment).

This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

Optometrist means a duly licensed optometrist.

Other Plan is an insurance plan other than this plan that provides medical, repatriation of remains, and/or medical evacuation benefits for the Insured Person.

Outpatient means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Partial Hospitalization Treatment Program means a planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

A **Participating Hospital** (in network) is a Hospital that has a Participating Hospital agreement in effect with the Insurer at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Participating Physician (in network) is a Physician who has a Participating Physician agreement in effect with the Insurer at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for Covered Services.

A Participating Provider (in network) is a Participating Physician, hospital, or other health care provider that has a Participating Provider agreement in effect with the Insurer at the time services are rendered. Participating Providers agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Pediatric Preventative Care means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a physician and rendered to a child.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Physical Therapist means a duly licensed physical therapist.

Physical Therapy means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits.

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits. Includes a licensed naturopathic physician working within the scope of his or license providing covered services or treatment.

Plan is the set of benefits described in the Certificate of Coverage booklet and in the amendments to this booklet (if any). This Plan is subject to the terms and conditions of the Policy the Insurer has issued to the Group. If changes are made to the Policy or Plan, an amendment or revised booklet will be issued to the Group for distribution to each Insured Participant affected by the change.

Podiatrist means a duly licensed podiatrist.

Policy is the Group Policy the Insurer has issued to the Group.

Preexisting Condition means any condition for which medical advice or treatment was recommended by or received from a legally qualified physician within 6 months prior to the Coverage Date for the insured.

A **Primary Plan** is a Group Health Benefit Plan, an individual health benefit plan, or a governmental health plan designed to be the first payor of claims for an Insured Person prior to the responsibility of this Plan.

Private Duty Nursing Service means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse that is not providing this service as an employee or agent of a Hospital or other health care facility. Private Duty Nursing Service does not include Custodial Care Service.

Provider or Professional Provider means any health care facility (for example, a Hospital) or person (for example, a Physician, Dentist, Podiatrist, Psychologist, or Chiropractor) or entity duly licensed to render Covered Services to you.

Psychologist means a Registered Clinical Psychologist.

A **Reasonable Charge**, as determined by the Insurer, is the amount it will consider for a Covered Expense with respect to charges made by a Physician, facility or other supplier for Covered Services. In determining whether a charge is Reasonable, the Insurer will consider all of the following factors:

- 1. The actual charge.
- 2. Specialty training, work value factors, practice costs, regional geographic factors and inflation factors.
- 3. The amount charged for the same or comparable services or supplies in the same region or in other parts of the country.
- 4. Consideration of new procedures, services or supplies in comparison to commonly used procedures, services or supplies.
- 5. The Average Wholesale Price for Pharmaceuticals.

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

Registered Clinical Psychologist means a Clinical Psychologist who is registered with a department of professional regulation or, in a state or country where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state or country where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

- 1. has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or
- 2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

Renal Dialysis Treatment means one unit of service including the equipment, supplies and administrative service that are customarily considered as necessary to perform the dialysis process.

Schedule of Benefits means the document attached to the Certificate showing the coverage and benefit amounts provided under your Group Policy.

The Insurer's Service Area is any place that is within twenty-five (25) miles of a Participating Provider.

Skilled Nursing Facility means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. This definition **excludes** any home, facility or part thereof used primarily for rest; a home or facility primarily for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

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.

Speech Therapist means a duly licensed speech therapist.

Speech Therapy means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psycho-social speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Substance Abuse Rehabilitation Treatment means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, or Clinical Professional Counselor, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment.

Surgery means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by our Authorized Administrator.

Temporomandibular Joint Dysfunction & Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Therapeutic Care means services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers for the Treatment of Autism Spectrum Disorders.

Totally Disabled means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Treatment of Autism Spectrum Disorders means the following care prescribed, provided, or ordered for an individual diagnosed with one or more autism spectrum disorders by a licensed Physician or a licensed psychologist if such physician or psychologist determines the care to be medically necessary:

- 1. Habilitative Care or Rehabilitative Care;
- 2. pharmacy care;
- psychiatric care;
- 4. psychological care; and
- Therapeutic Care.

Usual & Customary (or U&C) Fee means the fee as reasonably determined by a Plan and/or our Authorized Administrator, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor, or Optometrist ("Professional Provider") who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists, Psychologists, Clinical Social Workers, Chiropractors, or Optometrists ("Professional Providers") of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

However, if a Plan and/or our Authorized Administrator reasonably determine that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by a Plan and/or our Authorized Administrator.

U.S. means the United States of America, including Puerto Rico and the US Virgin Islands.

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 {Policy/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/Calendar} Year. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received from either Participating or Non-Participating Providers each {Policy/Calendar} Year before any benefits are available. The Annual Deductible does not apply to those Office Visits for which a Copayment is required. Annual maximum Deductibles (if any) for the Insured Eligible Participant and his/her Eligible Dependents is stated in the Overview Matrix.

Coinsurance Maximums

The Coinsurance Maximum is the amount of Copayment each Insured Person incurs for Covered Expenses in a {Policy/Calendar} Year. The Coinsurance Maximum **does not** include any amounts in excess of Covered Expenses, Prescription Drug Deductible or Copayments, Annual Deductible, amounts applied to any penalties, or any amounts in excess of other benefit limits of this Plan.

The in network (Participating Providers) Coinsurance Maximum per Insured Person per {Policy/Calendar} Year is as stated in the Overview Matrix.

The **out-of-network** (Non-Participating Providers) Coinsurance Maximum per Insured Person per {Policy/Calendar} Year is as stated in the Overview Matrix.

Once the **in network** (Participating Providers) Coinsurance Maximum is met, the Insurer will pay the percentage of Reasonable Charges for Non-Participating Providers for the remainder of the {Policy/Calendar} Year as stated in the Overview Matrix.

Once the **out of network** (Non-Participating Provider) Coinsurance Maximum is met, the Insurer will pay the percentage of Reasonable Charges for Non-Participating Providers for the remainder of the {Policy/Calendar} Year as stated in the Overview Matrix.

In addition, if an Insured Participant has any Insured Dependents, once the Insured Participant and the Insured Dependents reach a the combined total of Coinsurance expenses from a Participating Provider (in network) as stated in the Overview Matrix, the Insurer will pay the percentage of the Negotiated Rate for Participating Providers for the remainder of the {Policy/Calendar} Year as stated in the Overview Matrix.

Plan Payment

After the Insured Participant satisfies any required Deductible, payment of Covered Expenses is provided as defined below:

First Level Payment

Until an Insured Persons satisfies his/her in network or out of network Coinsurance Maximum in a {Policy/Calendar} Year, the Insurer pays:

- 1. The balance of the Covered Expense after the Insured Person pays the Copayment for Office Visits to Participating Providers as stated in the Overview Matrix. The number of visits per {Policy/Calendar} Year for which the Insurer will pay is limited as stated in the Overview Matrix.
- 2. The percentage of Covered Expenses as stated in the Overview Matrix for routine pap smears and annual mammograms obtained from either a Participating or Non-Participating Provider.
- The percentage of Covered Expense for Office Visits to Non-Participating Providers as stated in the Overview Matrix.
- 4. The percentage of Covered Expense for all other Covered Services obtained from a Participating Provider as stated in the Overview Matrix. The Insured Person pays the balance of the Covered Expense. Participating Providers will not charge more than the Negotiated Rate.
- 5. The percentage of Covered Expense for all other Covered Services obtained from a Non-Participating Provider. The Insured Person pays the balance of the Covered Expense, plus any amount in excess of the Covered Expense.

Second Level Payment

Once an Insured Person satisfies his/her in network (Participating Provider) Coinsurance Maximum in a {Policy/Calendar} Year, the Insurer pays:

- 1. The percentage of the Negotiated Rate as stated in the Overview Matrix for all other Covered Expenses obtained from a Participating Provider.
- 2. The percentage of the Reasonable Charge as stated in the Overview Matrix for Covered Expenses for routine pap smears and annual mammograms obtained from a Non Participating Provider.
- 3. The percentage of the Reasonable Charges as stated in the Overview Matrix for all other Covered Expenses obtained from a Non-Participating Provider.

Please note any additional limits on the maximum amount of Covered Expenses in the Schedule of Benefits and the discussions of each specific benefit.

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 the Overview Matrix and the Schedule of Benefits.

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. Whenever the term "you or your" is used, it is meant to mean all eligible Insured Person's as described in described under the Eligibility Section of this document.

Preventive Care Services

Benefits will be provided for preventive care services rendered to an Insured Person, even though they are not ill. Services described below received while outside the United States or inside the United States at an in-network provider will not be subject to a deductible, co-payment or co-insurance. Benefits will be limited to the following services:

Coverage for Preventative Items and Services

- Except as otherwise provided in Subsection 2 below, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved:
 - a. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
 - b. With respect to infants, children and adolescents, evidence-informed preventive care, and screenings, including hearing loss screenings, provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - c. With respect to women, to the extent not described in Subsection 1.a., evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- 2. The Insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection 1 after the recommendation or guideline is no longer described in Subsection 1.
 - a. The Insurer will give sixty (60) days advance notice to the Eligible Participant before any material modification to the services in Subsection 1 become effective.

Additional Benefits Provided: Benefits will be limited to the following services:

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes. Benefits will be provided if these services are prescribed by a health care professional legally authorized to prescribe such training and education under law and rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management.

Benefits for such health care professionals will be provided at the same benefit levels as those provided for any other covered condition.

Diabetes Equipment and Supplies

Benefits are also available for diabetes equipment and supplies prescribed by a health care professional legally authorized to prescribe such equipment and supplies under law for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes.

Benefits for such equipment and supplies will be provided at the same benefit levels as those provided for any other covered condition.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or Pap smear test for females aged 18 and older.

Mammograms

- 1. a baseline mammogram for asymptomatic women at least 35 years of age;
- 2. a mammogram every 1 to 2 years for asymptomatic women age 40 to 50, but no sooner than 2 years after a baseline mammogram;
- 3. a mammogram every year for asymptomatic women age 50 and over.

Benefits will also be provided for any woman when a Physician's evaluation of a woman's physical conditions, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

Prostate Test and Digital Rectal Examination Benefits will be provided for routine prostate-specific antigen tests and digital rectal examinations in accordance with American Cancer Society guidelines.

Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening for persons 50 years of age or older. Screening includes:

- An annual fecal occult blood tests (3 specimens).
- 2. A flexible sigmoidoscopy every 5 years.
- 3. A colonoscopy every 10 years.
- 4. A double contrast barium enema every 5 years.

In addition, benefits will be provided for people who are considered to be high risk for colon cancer because of:

- 1. Family history of familial adenomatous polyposis;
- 2. Family history of hereditary nonpolyposis colon cancer;
- 3. Chronic inflammatory bowel disease;
- 4. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- 5. A background, ethnicity or lifestyle is determined to be at elevated risk.

[Annual Physical Examination/Health Screening

An Annual Physical Examination or Health Screening for services not covered under the Preventive Care Services above included in the coverage according to the limits stated in the Schedule of Benefits.]

[Travel Vaccinations/Immunizations

Recommended travel vaccinations/immunizations not covered under the Preventative Care Services above are covered according to the limits stated in the Schedule of Benefits.]

Services Provided by a Physician

Surgery

Benefits are available for Surgery performed by a Physician or Dentist. However, for services performed by a Dentist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

- 1. [surgical removal of complete bony impacted teeth;]
- 2. excisions of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- 1. Anesthesia Services if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
- 2. Assistant Surgeon that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

Benefits for Surgery will be provided at the percent level shown in the Schedule of Benefits.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at the percentage of the Claim Charge as shown in the Schedule of Benefits. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

[After your Copayment,] Benefits for Additional Surgical Opinion will be provided at the percent level shown in the Schedule of Benefits.

Medical Care

Benefits are available for Medical Care visits when:

you are an Inpatient in a Hospital or Substance Abuse Treatment Facility; or

- 2. you are a patient in a Partial Hospitalization Treatment Program; or
- 3. you visit your Physician's office or your Physician comes to your home.
- 4. After any Copayment, Medical Care Benefits are provided at the percent shown in the Schedule of Benefits.

Other Physician Services

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the **Special Conditions & Payments** section of this Certificate.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Chemotherapy

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits for any Physician or Hospital charges associated with treatment. Your coverage includes benefits for Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits.

Radiation Therapy treatments

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits for any Physician or Hospital charges associated with treatment.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association or similar body. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits will be provided as shown in the Schedule of Benefits.

Other Specified Therapies

Benefits will be provided as shown in the Schedule of Benefits for other Specified Therapies, which include: Biofeedback, Chelation Therapy, Hearing Therapy, Orthoptics & Vision Therapy, Pulmonary and Respiratory Rehabilitation. Services must be rendered by a licensed Provider and must be prescribed to treat a covered illness or injury.

Diagnostic Service

Benefits will be provided for those services related to covered Surgery or Medical Care.

Benefit Payment for other Physician Services

Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits when you receive any of the Covered Services described in this Physician Benefit Section from a Provider or from a Dentist.

Emergency Accident or Medical Care

Treatment must occur within 72 hours of the accident.

Benefit Payment for Emergency Accident or Medical Care

[After your Copayment,] Benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits.

Services and Supplies Provided by a Hospital

Inpatient Care

The following are Covered Services when the Insured Person receives them as an Inpatient in a Hospital.

Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits when you receive Inpatient Covered Services. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Inpatient Covered Services

- 1. Bed, Board and General Nursing Care when you are in:
 - a. a semi-private room
 - b. a private room (at semi-private room rate)
 - c. an intensive care unit
- 2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Payment of Inpatient Covered Expenses are subject to these conditions:

- 1. Services must be those, which are regularly provided and billed by the Hospital.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.
- 3. No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery that you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

[Parental Accommodation

Hospital charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12. Benefits are limited to a maximum of \$500 per inpatient admission.]

Extension of Benefits in Case of Termination

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate that are rendered by and regularly charged for by a Hospital. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

Outpatient Hospital Care

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

- 1. Surgery and any related Diagnostic Service received on the same day as the Surgery
- 2. Radiation therapy treatments
- 3. MRI
- Chemotherapy
- Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis
 Facility
- 6. Diagnostic Service when you are an Outpatient and these services are related to surgery or Medical Care
- Emergency Accident Care treatment must occur within seventy-two (72) hours of the accident
- 8. Emergency Medical Care

Outpatient Hospital Care Benefit Payment

[After you have met your Copayment,] Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits.

Benefit Payment for Hospital Emergency Care

After you have met your Copayment, benefits will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits when you receive Emergency Accident Care or Emergency Medical Care.

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

Other Covered Services and Special Conditions

Ambulance Transportation

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.

Non Covered Services for Ambulance include but are not limited to, trips to:

- 1. a Physician's office or clinic;
- a morgue or funeral home.
- 3. for long distance trips or for use of an ambulance because it is more convenient than other transportation

Ambulatory Surgical Facility

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Ambulatory Surgical Facility for Outpatient Surgery will be provided as shown in the Schedule of Benefits.

EXAMPLE : Autism Spectrum Disorders – Diagnosis and Treatment in Covered Children

Coverage is provided for the diagnosis and Treatment of Autism Spectrum Disorders and includes Applied Behavior Analysis supervised by a nationally board-certified behavior analyst and provided by a licensed Autism Services Provider for Covered Dependents beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

Benefits are payable on the same basis as any other sickness.

Services for Mental Illnesses

Both inpatient and outpatient coverage is provided for the diagnosis and treatment of Mental Illness. Benefits for Mental Illness services are the same as benefits for any other condition as specified in the Schedule of Benefits.

Cardiac Rehabilitation Services

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.

Chiropractor Services

Exams, testing or manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractor Services as specified in the Schedule of Benefits.

Cleft Lip and Cleft Palate

Coverage shall be provided for Inpatient or Outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.

Cancer Clinical Trials

Benefits will be provided for routine costs for Covered Persons who participate in approved cancer clinical trials conducted under the auspices of the following cancer care providers ('cancer care providers'):

- 1. Vermont Cancer Center at Fletcher Allen Health Care:
- 2. The Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center; and
- 3. any Hospital and its affiliated, qualified cancer care providers.

For participation in clinical trials located outside Vermont, coverage under this benefit will be provided only if the Covered Person provides notice to the health benefit plan prior to participation in the clinical trial, and:

- 1. no clinical trial is available at a Vermont or New Hampshire cancer care provider described above;
- 2. the Covered Person has already completed a clinical trial at an approved cancer care provider listed above and that provider has determined that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available at that time under an approved cancer care provider listed above; or
- 3. a. The health plan has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available; and

b. the patient's cancer care provider determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available under an approved cancer care provider listed above.

If a Covered Person participates in a clinical trial administered by a cancer care provider that is not in the health benefit plan's provider network, the health plan may require that routine follow-up care be provided within the health benefit plan's network, unless the cancer care provider determines this would not be in the best interest of the Covered Person.

As used in this benefit, "health benefit plan" means the Policy or any other applicable health benefit plan offered by the Insurer.

Dental Care for an Accidental Injury

Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. No benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

Covered Services for accidental dental include, but are not limited to:

- 1. oral examinations:
- 2. x-rays;
- 3. tests and laboratory examinations;
- 4. restorations;
- 5. prosthetic services;
- 6. oral surgery;
- 7. mandibular/maxillary reconstruction;
- 8. anesthesia.

Benefits are payable as stated in the Schedule of Benefits.

Durable medical equipment

Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose

Hormone Replacement Therapy

If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

Human Organ Transplants

Your benefits for certain human organ transplants will be limited to the amount as shown in the Schedule of Benefits. Benefits will be provided only for kidney, heart valve, heart, lung, heart/lung, or liver transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- 1. If both the donor and recipient have coverage with the Insurer, each will have their benefits paid by their own policy.
- 2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided only for you and not the donor.
- 3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.
- 4. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

In addition to the above provisions, benefits for heart, lung, heart/lung, or liver transplants will be provided as follows:

- 1. Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.
- Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.

- 3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.
- 4. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
 - a. Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery
 - b. Transportation by air ambulance for the donor or the recipient
 - c. Travel time and related expenses required by a Provider
 - d. Drugs that are Investigational
 - e. The cost of acquisition of the organ and any costs incurred by the donor

[Infertility

Covered services related to the diagnosis of infertility shall be same as any other condition.

Covered Services related to the treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer will be provided as shown in the Schedule of Benefits.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- 1. you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and
- you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Special Limitations for Infertility Services

Benefits will not be provided for the following:

- 1. Services rendered to a surrogate mother for purposes of childbirth
- Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures that use a cryo-preserved substance
- 3. Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization or other such body as approved by the Authorized Administrator.]

Infusion Therapy

Infusion Therapy is the administration of Drugs (Prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by feeding tube.

Covered Expense for Infusion Therapy (including all professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy) will not exceed the Average Wholesale Price as determined by the Insurer or the Negotiated Rate:

Covered Services for Infusion Therapy are as follows:

- 1. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
- 2. All necessary supplies and durable medical equipment including, but not limited to, bandages, cotton swabs, intravenous starter kits, tubing, syringes, needles, pump, pole, and electronic monitor.
- 3. The Infusion Therapy Drugs or other substances.
- 4. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

Conditions, Limitations, Exclusions applicable to Infusion Therapy benefits are as follows:

- 1. If performed in the home, services must be billed and performed by a provider licensed by state and local laws. Example: A Medicare-certified Home Health agency or a provider certified by the Joint Commission on Accreditation of Home Care Organizations.
- 2. If performed in any other outpatient setting, services must be billed by a qualified provider as defined in this Plan and licensed by state and local laws. Example: Physician's office, outpatient Hospital or Ambulatory Surgical Center.
- 3. The services must be consistent with the Illness, Injury, degree of disability and medical needs of the Insured Person receiving treatment. Benefits are provided for Covered Services only for the Authorized number of days necessary to treat the Illness or Injury, subject to the per-day maximum.
- 4. Services and Drugs or other substances used must be consistent with the accepted medical practice and not investigative or experimental.
- 5. For treatment, which has been prescribed and Authorized for a period greater than 7 days, only up to a 7-day supply per delivery is to be dispensed.
- 6. In addition to any per-day maximum, limitations on Pre-Existing Conditions or other exclusion or limitations in this entire Plan, Infusion Therapy benefits will <u>not</u> 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, unless treatment is 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.

Medical Foods and Modified Food Products

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products when diagnosed and determined to be Medically Necessary by the Insured Person's Physician, and administered under the direction of a Physician.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry screened in newborn babies.

"Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means an amino acid modified preparation that is intended to be used under direction of a Physician for the dietary treatment of an inherited metabolic disease.

Benefits are provided to the same extent as for any other Illness under the Policy.

Ovarian Cancer Monitoring

Coverage shall be provided for CA-125 monitoring of ovarian cancer subsequent to treatment. This does not apply to routine screenings.

Other Covered Service

- 1. Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture
- 2. Allergy shots and allergy surveys
- 3. Blood and blood components
- 4. Leg, back, arm and neck braces
- 5. Oxygen and its administration
- 6. Medical and surgical dressings, supplies, casts and splints
- 7. Lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with quidelines set forth by the Division of Public Health

Scalp hair prosthesis Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease. Benefits are payable for up to \$500 per {Policy/Calendar} Year

Pregnancy and Maternity Care

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Maternity benefits are **not** available for any Insured Person other than the Insured Participant or the Insured Participant's insured spouse or civil union partner [or domestic partner].

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when our Authorized Administrator determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family

Prosthetic appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

- 1. they are required to replace all or part of an organ or tissue of the human body, or
- 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders and replacement of cataract lenses when a prescription change is not required)

Sterilization

The Insured Participant's Plan includes benefits for tubal ligation or vasectomy.

Treatment to Bones or Joints in the Face, Neck or Head<8 VSA s 4089g; this mandate covers TMJ and replaces the above provision.> Benefits will be provided for the diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage will be:

- 1. the same as that provided under the Policy for any other musculoskeletal disorder in the body; and
- 2. provided when prescribed or administered by a Physician or a Dentist.

This benefit does not require coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

[Home Health Care

Home Health services are limited each Policy Year as stated in the Schedule of Benefits for the following services. Services must be furnished by a Home Health Agency or a Visiting Nurses Association.

Benefits are provided when the Insured Participant or Insured Dependents are confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. A visit is defined as four or fewer hours of services provided by one of the following providers:

- 1. Services of a registered nurse.
- 2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- 3. If the Insured Person is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- 4. Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- 5. Services of a medical social worker.

All home health care services and supplies directly related to Infusion Therapy are included in the Infusion Therapy benefit and are not payable under this home health care benefit.].

[Hospice Services

Benefits for Hospice services are limited as stated in the Schedule of Benefits.

The Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is 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.

Services and Supplies Provided by a Skilled Nursing Facility

Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

For any eligible condition that is Insurer Authorized, the Insurer will pay Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:

- 1. The Insured Person must be referred to the Skilled Nursing Facility by a Physician.
- 2. Services must be those, which are regularly provided and billed by a Skilled Nursing Facility.
- 3. The services must be consistent with the Insured Person's Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
- 4. The Insured Person must remain under the active medical supervision of a Physician treating the Illness or Injury for which he/she is confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- 1. Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the number of days as indicated in the Schedule of Benefits.

Hearing Services

[Hearing Services include audiometric exams, hearing aid evaluation test, and limited benefits for hearing aids. See the Schedule of Benefits for maximums, which apply for Hearing Services.]

For Covered Persons who are Dependent Children under age 24, coverage provided for hearing aids up to the amount shown in the Schedule of Benefits.

[Vision Care

The Insurer will pay for Covered Expenses per Policy Year as stated in the Schedule of Benefits for routine Vision Care that is not the result of an Injury or Illness. The Deductible is not applicable.

Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the WHO IS ELIGIBLE FOR COVERAGE, DEFINITIONS, and EXCLUSIONS AND LIMITATIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and you must receive such care on or after your Coverage Date.

In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

- 1. Contact Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.
- 2. Frame means a standard eyeglass frame adequate to hold Lenses.
- 3. Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Covered Services

Benefits may be provided under this Benefit Section for the following:

- 1. Vision Examination
- 2. Single Vision Lenses
- 3. Bifocal Single Lenses
- 4. Bifocal Double Lenses
- Trifocal Lenses
- Lenticular Lenses

- Contact Lenses
- Frames

Special Limitations

Benefits will not be provided for the following:

- 1. Recreational sunglasses.
- 2. Medical or surgical treatment.
- 3. Drugs or any medication not administered for the purpose of a vision testing examination.
- 4. Orthoptics, vision training, subnormal vision aids, aniseikonic Lenses and tonoraphy.
- 5. Replacement of Lenses or Frames, which are lost or broken.

Benefit Payment for Vision Care

Benefits for Vision Care Covered Services will be provided for the services and at the payment levels listed in the Schedule of Benefits.]

[Dental Care

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the WHO IS ELIGIBLE FOR COVERAGE, DEFINITIONS, and EXCLUSIONS AND LIMITATIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Insurer until after receipt of a Dentist's or Physician's Claim form and/or the Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

The maximum amount available for you in dental benefits each Benefit Period is shown in the Schedule of Benefits. This is an individual maximum. This maximum applies to all of your Dental Covered Services, except for Orthodontic Dental Services where the maximum is the amount shown in the Schedule of Benefits.

Any expenses incurred beyond the benefit maximum are your responsibility.

Preventative Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for preventative treatment and necessary diagnostic examinations. Your Preventive Dental Services are as follows:

- 1. Oral Examinations The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every Benefit Period;
- 2. Prophylaxis The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each Benefit Period;
- 3. Topical Fluoride Application Benefits for this application are only available to dependent children under age 19 and are limited to two applications each Benefit Period:
- 4. Dental X-rays Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every twelve months;
- 5. Space Maintainers Benefits for space maintainers are only available to dependent children under age 19 and not when part of orthodontic treatment;
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Primary Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Primary Dental Services. Covered Expenses include:

- Fillings
- 2. Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section
- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Endodontics
- 5. Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- 6. Apicoectomies
- 7. Hemisection
- 8. Biopsies of Oral Tissue
- 9. Periodontics/Periodontal Therapy; Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
- 10. Periodontal examination Benefits for periodontal examinations are limited to two per Benefit Period
- 11. Periodontal maintenance procedures Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
- 12. Stainless Steel Crowns
- 13. Repair of Removable Dentures
- 14. Recementing of Crowns, Inlays, Onlays and Bridges
- 15. General Anesthesia/Intravenous Sedation If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation

16. Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

[Primary Dental Services are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.]

Major Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Major Dental Services. Covered Expenses Include:

- 1. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- 2. Fixed Bridgework
- 3. Bridge Repairs
- 4. Full and Partial Dentures
- 5. Denture Adjustments, Rebasing and Relining During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture that could have been made serviceable.

Major Dental Services are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.

[Orthodontic Dental Care

Orthodontic Dental Care applies only if the Group has chosen Dental Care and Orthodontic Dental Care as shown in the Schedule of Benefits.

The Insurer pays the percentage of Covered Expenses indicated in the Schedule of Benefits for necessary orthodontic treatment subject to a specific lifetime maximum also shown in the Schedule. Once this lifetime limit is reached, the Insured Person has no right to any further orthodontic treatment benefits.

[Up to the age of 19,]Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. The limitations are as follows:

- 1. Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist;
- 2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment

After your orthodontic treatment has been completed, no further orthodontic benefits will be provided until 5 years have elapsed.

[Orthodontic expenses are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.]

Special Limitations

No benefits will be provided under this Benefit Section for:

- 1. Dental services which are performed for cosmetic purposes.
- 2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
- 3. Oral Surgery for the following procedures:
 - a. surgical services related to a congenital malformation;
 - b. surgical removal of complete bony impacted teeth;
 - c. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
- 4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
- 5. Hospital and ancillary charges are not covered.
- 5. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
- 7. Any services, treatments or supplies included as an eligible benefit under other group hospital, dental, medical and/or surgical coverage.]

[Accidental Death and Dismemberment Benefit

The Insurer will pay the benefit stated below if an Insured Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss Benefit

Loss of life 100% of the Principal Sum

Loss of one hand50% of the Principal SumLoss of one foot50% of the Principal SumLoss of sight in one eye50% 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.]

[Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Insured Persons in any one Accident or disaster shall not exceed the sum of <\$300,000 - \$500,000>. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed <\$300,000 - \$500,000> the amount of indemnity payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed <\$300,000 - \$500,000>.]

[Repatriation of Remains Benefit

If an Insured Person dies, while traveling outside of his/her home country, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Authorized 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 Authorized 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 Authorized Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Overview Matrix, 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 Authorized 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.

If you have minor children who are left unattended as a result of your injury, illness or medical evacuation, our Authorized Administrator will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to your Home Country or Country of Assignment.

The combined benefit for all necessary evacuation services is listed in the Overview Matrix.]

[Bedside Visit Benefit

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than <3 – 7> days, is likely to be hospitalized for more than <3 – 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 <3 – 7> days or is in critical condition shall be made by the Authorized 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 Authorized 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

1. The following services and supplies are not covered:

Hospitalization, services and supplies that are not Medically Necessary.

No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately
 in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Authorized Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Insurer will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Insurer, either at law or in equity. To initiate your appeal, you must give Insurer written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

Remember, even if your Physician prescribes, orders, recommends, approves or views hospitalization or other health care services and supplies as Medically Necessary, the Insurer will not pay for the hospitalization, services and supplies if its authorized administrator decides they were not Medically Necessary

- 2. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are provided under any Workers' Compensation Law or other similar laws. [This exclusion does not apply to Protection and Indemnity Insurance for Marine crew members.]
- 3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided by a local, state or federal government.
- 4. Services and supplies for any illness or injury occurring on or after your Coverage date as a result of war or act of war (whether declared or

- undeclared), participation in a felony, riot or insurrection.
- Custodial Care Service.
- 6. Routine physical examinations, unless otherwise specified in this Certificate.
- 7. Cosmetic Surgery and related services and supplies, except reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- 8. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- 9. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- 10. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- 11. [Foot care, except for persons diagnosed with diabetes, in connection with corns, calluses, flat fee, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.]
- 12. [Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.]
- 13. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- 14. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- 15. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- 16. Consultations performed by you, your spouse, parents or children.
- 17. [Treatment for hair loss.]
- 18. [Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).]
- 19. [Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.]
- 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. [Contact lenses and glasses unless otherwise specified in this Certificate.]
- 22. [Services and treatment related to elective abortions.]
- 23. [Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate.]
- 24. [Elective Abortions]
- 25. [Dental services unless elected by your Group.]
- 26. [Vision care services unless elected by your Group]
- 27. [Loss arising from [ultra light aircraft], [parasailing], [sail planning], [hang gliding].]

[Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to pregnancy, congenital anomalies of a covered dependent, a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, or Insured Dependents under age 19.

Exception: The Insurer will credit time an Insured Person was covered by Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of Coverage under this Plan, excluding the Waiting Period.

This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.]

VII. Prescription Drug Benefits

Introduction and Definitions

To understand the Insured Person's Prescription Drug Benefits, it may be helpful to review these important terms:

Average Wholesale Price (AWP) is the average wholesale price of a Drug as determined by the Insurer.

Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented and is only produced by one manufacturer.

Drugs (Prescription Drugs) mean Prescription Drugs approved by state law or the Federal Food and Drug Administration for general use by the public. (See section on Conditions of Service for exceptions.) For purposes of this benefit, insulin is considered a Prescription Drug.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Maintenance Prescription Drugs are Prescription Drugs that are taken for an extended period of time to treat a medical condition.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. Call the Insured Person's local Pharmacy or call the toll-free Prescription Benefit Customer Service phone number (x-xxx-xxx-xxxx) for a list of Participating Pharmacies in the Insured Person's area.

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

- 1. Outpatient Drugs and medications that federal and/or State law restrict to sale by Prescription only.
- 2 Insulin
- 3. Insulin syringes prescribed and dispensed for use with insulin.
- 4. All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.

Prescription drugs purchased in Canada, and used in Canada or re-imported legally or purchased through the I-SaveRx program, will be covered on the same benefit terms and conditions as prescription drugs purchased in the U.S.

Conditions of Service

The Drug or medicine must be:

- 1. Prescribed in writing by a Physician and dispensed within one Calendar Year of being prescribed, subject to federal or state laws.
- 2. Approved for use by the Food and Drug Administration.
- 3. For the direct care and treatment of the Insured Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included.
- Purchased from a licensed retail Pharmacy.

The drug or medicine must **not** be used while the Insured Person is an inpatient in any facility.

The Prescription must not exceed a <30 – 180> -day supply.

Reimbursement

Many Prescription Drugs are available in Generic form, which is more cost effective for the Insured Person. It may be to the Eligible Participant's advantage to ask the Insured Person's Physician to prescribe and the Insured Person's pharmacist to dispense Generic Drugs whenever possible.

The amount reimbursed by the Insurer for claims for Prescription Drugs is separate from and will not be applied toward any coinsurance amount described in the Covered Services section of this Plan.

When the Insured Person Goes to a Participating Pharmacy

When the Insured Person or an Insured Dependent has a Prescription filled, the Insured Person's identification card should be presented and the Insured Person should identify himself/herself as an Insured Person of the Insurer. The Pharmacy will calculate the Insured Person's remaining deductible and Copayment. The Insured Person will not need to submit claim forms but is responsible for paying Deductible and Co-insurance amounts to the Pharmacy. The Insured Person will have the following Copayment for each covered Prescription and/or refill after his/her Deductible is satisfied:

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 3. For injectable, the Insured Person pays as stated in the Schedule of Benefits.

When the Insured Person Goes to a Non-Participating Pharmacy

If the Insured Person purchases a Prescription Drug from a Non-Participating Pharmacy, he/she will be responsible for the amount stated in the Schedule of Benefits as well as any charge, which exceeds the Reasonable Charge of the Drug. He/she will need to have the pharmacist complete his or her portion of the Prescription Drug Claim Form. The Insured Person will pay the pharmacist for the Prescription, complete the Insured Person's portion of the Prescription Claim Form and then submit the Eligible Participant's claim to the Insurer for reimbursement within 15 months of the date of purchase. If the Insured Person has not satisfied his/her Deductible at the time his/her claim is submitted, the amount the Insured Person paid for the Prescription may be applied toward his/her Deductible amount. The Insured Person's Prescription is considered purchased on the date he/she receives the Drug for which the charge is made. The completed claim form should be submitted to the address included on the Prescription Claim Form.

When the Insured Person has his/her Prescription filled at a Non-Participating Pharmacy he/she will be reimbursed at the following rate for each covered Prescription and/or refill after the Insured Person's deductible is satisfied:

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits plus any amount over Reasonable Charges.
- 2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits, plus any amount over Reasonable Charges.

Claims and Customer Service

Drug claim forms are available at Participating Pharmacies or upon written request to Insurer.

If the Insured Person has any questions about his Prescription Drug Benefit, call the toll-free customer service number: [x-xxx-xxxx.]

Prescription Drug Exclusions and Limitations

Prescription Drug reimbursement is subject to and treated as part of any benefit maximums, limitations on Pre-existing Conditions or any other exclusions or limitations contained in this entire Plan. In addition, reimbursement will not be provided for:

- 1. Drugs and medications not requiring a Prescription, except insulin.
- 2. Self-administered injectable drugs, except insulin.
- 3. Non-medical substances or items.
- [[Contraceptive Drugs and [certain]] devices prescribed for birth control,] [Drugs and medications used to induce non-spontaneous abortions.]]
- 5. Dietary supplements, cosmetics, health or beauty aids.
- 6. Any vitamin, mineral, herb or botanical product, which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
- 7. Drugs taken while the Eligible Participant are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
- 8. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
- 9. Syringes and/or needles, except those dispensed for use with insulin.
- 10. Durable medical equipment, devices, appliances and supplies.
- 11. Immunizing agents, biological sera, blood, blood products or blood plasma.
- 12. Oxygen.
- 13. Professional charges in connection with administering, injecting or dispensing of Drugs.
- 14. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
- 15. Drugs used for cosmetic purposes.
- 16. Drugs used for sexual stimulation.
- 17. Drugs used for treating hair loss.
- 18. [Drugs used for the primary purpose of treating infertility.]
- 19. Anorexiants or Drugs associated with weight loss.
- 20. Allergy desensitization products, allergy serum.
- 21. All Infusion Therapy is excluded under this Plan except as specifically stated in the Covered Services section.
- 22. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Preexisting Condition, or other contract limitation.
- 23. Growth Hormone Treatment.
- 24. Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
- 25. [The replacement of lost or stolen Prescription Drugs.]
- 26. [Antihistamines.]

VIII. General Provisions

Third Party Liability

No benefits are payable for any Illness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Insurer will advance the benefits of this Plan to the Insured Person subject to the following:

- 1. The Insured Participant agrees to advise the Insurer, in writing, within 60 days of any Insured Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as the Insurer may require to facilitate enforcement of the claim. The Insured Participant and Insured Person also agree to take no action that may prejudice the Insurer's rights or interests under this Plan. Failure to provide notice of a claim or to cooperate with the Insurer, or actions that prejudice the Insurer's rights or interests, will be material breach of this Plan and will result in the Insured Participant being personally responsible for reimbursing the Insurer.
- 2. The Insurer will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Insured Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by the Insurer under this Plan for the treatment of the Illness, disease, Injury or condition for which the third party is liable.

Coordination of Benefits (COB)

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 Policy Year, and are largely determined by 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;
- 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:

- A plan, which has no Coordination of Benefits provision, pays before a plan, which has a Coordination of Benefits provision.
- 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 written proof of such loss. Should the Insurer fail to pay the benefits payable under the Plan, the Insurer shall have 15 workings days thereafter within which to mail the Insured Person a letter or notice which states the reasons the Insurer may have for failing to pay the claim, either in whole or in part, and which also gives the Insured Person a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim has been received, the Insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the Insured Person the reasons the Insurer may have for denying such claim or any portion thereof.

Subject to proof of loss, all accrued benefits payable under the Plan for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the Insurer are liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Time Payment of Claims: Benefits for a loss covered under this Plan will be paid as soon as the Insurer receives proper written proof of such loss. Any benefits payable to the Eligible Participant and unpaid at the Eligible Participant's death will be paid to the Insured Person's estate.

Payment of Claims: The Insurer may pay all or a portion of any indemnities provided for health care services to the participating health care services provider, unless the Insured Participant directs otherwise in writing by the time proofs of loss are filed. The Insurer will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services provider directly to the Insured Person, unless the Insured Participant directs otherwise in writing by the time proofs of loss are filed. The Insurer cannot require that the services be rendered by a particular health care services provider.

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:

- 1. It is duly executed on a form acceptable to the Insurer; and
- 2. A copy is on file with the Insurer.

The Insurer assumes no responsibility for the validity or effect of an assignment.

Payment for services provided by a Participating Provider is automatically assigned to the provider. The Participating Provider is responsible for filing the claim and the Insurer will make payments to the provider for any benefits payable under this Plan. Payment for services provided by a Non-Participating Provider are payable to the Insured Participant unless assignment is made as above.

Payment to a Managing Conservator: Benefits paid on behalf of a covered dependent child may be paid to a person who is not the Insured Participant, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the child.

To be entitled to receive benefits, a managing conservator of a child must submit to the Insurer with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured Participant where the Insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

Misstatement of Age: If the age of an Insured Person has been misstated, an adjustment of premiums shall be made based on the Insured Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

Right to Recovery: If the Insurer makes benefit payments in excess of the benefits payable under the provisions of the Plan, the Insurer has the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.

Plan Administrator. In no event will the Insurer be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than the Insurer, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Eligible Participant's agent.

Waiver of Rights: Failure by the Insurer to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

Physical Exam and Autopsy: The Insurer has the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Insured Participant will not have to pay for it.

Required Information: The Group will furnish the Insurer all information necessary to calculate the Premium and all other information that the Insurer may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. The Insurer has the right to examine any records of the Group, any person, company or organization which may affect the Premiums and benefits of the Plan.

The Insurer's right to examine any records that exist:

- 1. During the time the Plan is in force; or
- 2. Until the Insurer pay the last claim.

The Insurer is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as independent contractors and not as employees, agents or representatives of the Insurer.

The Insurer will provide written notice to the Insured Participant within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if the Insurer determines that the Insured Participant or his/her Insured Dependents may be materially and adversely affected, and provide the Insured Participant with a current list of Participating Providers.

The Insurer will provide the Group with an updated list of local Participating Providers annually. If the Insured Participant needs a new provider listing for any other reason, he/she may call the Insurer at, and the Insurer will provide the Insured Participant with one.

The Insurer is entitled to receive from any provider of service information about the Insured Person which is necessary to administer claims on the Insured Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Insured Participant has authorized every provider furnishing care to disclose all facts pertaining to the Insured Participant's and his/her Insured Dependent's care, treatment, and physical condition, upon the Insurer's request. The Insured Participant agrees to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services.

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS.

Grievance Procedures: If the Insured Person's claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

Review and determination of mental health claims may only be made by a licensed Mental Health Review Agent with the concurrence of a Mental Health Care Professional whose training and expertise is at least comparable to that of the treating clinician.

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:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

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.

Appeal Process

Expedited Claim Appeal

When an appeal concerns (a) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (b) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, you may request your appeal to be expedited.

Upon submission of an expedited appeal, you will be notified as soon as possible, but no later than 72 hours after the appeal is filed and the review agent receives all information necessary to complete the appeal.

First Level Appeal

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied, you may appeal your Claim. You may submit any additional information and comments on your Claim and you must request an appeal no later than 60 days after the denial by writing to:

Authorized Administrator Address City, State, zip code Telephone number: xxx-xxx-xxxx

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. If we require additional information, we will advise you within the first three days of your request.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Second Level Appeal

If your first level appeal is unsuccessful, and you want your appeal to be reviewed, you may request a second level appeal. You must request a second level appeal no later than 60 days after the first level appeal by writing to:

Authorized Administrator Address City, State, zip code Telephone number: xxx-xxx-xxxx

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. You may add information to the file by submitting it in writing.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Independent External Review

When a Covered Person has exhausted all applicable internal review procedures provided by the Insurer, such Covered Person will have the right to an independent external review of any decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review will be available when requested in writing by the affected insured, provided the decision to be reviewed requires the Insurer to expend at least \$100.00 for the service and the decision by the plan is based on one of the following reasons:

- 1. The health care service is a covered benefit that the health insurer has determined to be not medically necessary.
- 2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and rules.
- 3. The health care treatment has been determined to be experimental, investigational or an off-label drug. A health benefit plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal, and shall decide such appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the commissioner.
- 4. The health care service involves a medically-based decision that a condition is preexisting.

The right to an independent review will not be construed to change the terms of coverage under the Policy.

The independent external reviews will be conducted:

- 1. By independent review organizations pursuant to a contract with the department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section; and
- 2. In accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

The Covered Person will:

- 1. be provided with adequate notice of their review rights under this section;
- have the right to use outside assistance during the review process and to submit evidence relating to the health care service;

- 3. pay an application fee of \$25.00 for each request for an independent external review of an appealable decision not to exceed a total of \$75.00 annually. The application fee may be waived or reduced based on a determination by the Commissioner of Insurance that the financial circumstances of the Covered Person warrants a waiver or reduction. The application fee will be paid by the Insurer, not the Covered Person, if the independent review organization reverses the Insurer's decision to deny payment for a health care service; and
- 4. Be protected from retaliation for exercising their right to an independent external review.

Other costs of the independent review will be paid by the Insurer.

The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan.

The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable state or federal laws.

The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure in accordance with Vermont law.

Decisions relating to the following health care services shall not be reviewed under this section, but shall be reviewed by the review process provided by law:

- 1. Health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan.
- 2. Health care services provided to inmates by the Department of Corrections.

BCS Insurance Company

Oakbrook Terrace, IL 60181

Certification of Compliance

RE: Group Major Medical Policy Form 54.1201 ER VT, et al.

- I, Linda Hickok, Assistant Vice President, certify to the best of my knowledge and belief that the attached forms comply with Vermont law, specifically the accident and health requirements of Regulation 80-1, and that:
- (1) only large employer-employee groups meeting the standards of 8 VSA § 4079(1) will be allowed to purchase this product; and
- (2) the forms will be issued only to large employer-employee groups meeting the standards of 8 VSA § 4079(1).

I further hereby certify to the best of my knowledge and belief that the attached forms comply with Regulation H-2009-03 (NILS designation H-09-3), the Consumer Protection and Quality Requirements for Managed Care Organizations.

| Signature: | Junia Y. Hilish | |
|------------|-----------------|--|
| | | |
| Data: | January 5, 2012 | |

Statement of Variables

GENERAL STATEMENTS: In no event will variables be less favorable to an insured than the minimum standards set forth in Vermont law.

Blue-faced type is either editing/issuing notations or comments meant to explain how the variable material is to be handled. **Red-faced** type is either illustrative "John Doe" information or the actual variables that will be made available. Numeric variables are shown in **Green** and range from minimum to maximum.

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

[Product Name] MAJOR MEDICAL EXPENSE INSURANCE

POLICYHOLDER: Employer ← Actual policyholder/employer's name shown here.

POLICY EFFECTIVE DATE: Month, Date, Year← Actual policy effective date shown here.

POLICY NUMBER: ### ("the Policy")← Actual policy number shown here.

STATE OF DELIVERY: Vermont

ADMINISTRATOR: ABC Administrator ← Name and address of plan administrator shown here.

This Policy is a legal contract between the Policyholder and BCS Insurance Company (Insurer). The consideration for this contract is the application and the payment of premiums as provided hereinafter.

AGREEMENT

This Policy, the Certificates issued under the policy, the application(s) of the Group form the entire contract between the Policyholder and the Insurer. Oral statements made by the Policyholder, by an Insured Person, by the Insurer's Agent, or by any other person are not part of this Policy. Only the Insurer's President or a Vice President may make changes for the Insurer. These changes must be in writing and attached to this Policy. The Insurer reserves the right to amend the Policy from time to time. The Insurer will pay, with respect to each Insured Person, the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy. This Policy is governed by the laws of the jurisdiction shown above. The sections set forth on the following pages are a part of this Policy and take effect on the Policy Effective Date and

POLICY TERM

Policy Effective Date: <MM/DD/YYYY ← Policy effective date shown here.

Policy End Date: <MM/DD/YYYY> ← First renewal date shown here.

Policy Termination Date: The Policy will continue in force for the while the required premiums are paid until the Policy End Date or the Policy is terminated by either the Policyholder or by the Insurer. At least 31 – 90 days advance written notice is required to terminate the Policy by either party.

Cancellation of Coverage under the Policy: A Group's coverage under the Policy may be canceled at any time after 31 – 90 days written notice mailed or delivered by the Insurer to the Group or by the Group to the Insurer.

If the Insurer cancels the coverage under the Policy, the Insurer will mail or deliver the written notice to the Group at the last address stated in the Insurer's records. If the Insurer cancels coverage under the Policy, cancellation takes effect at 11:59:59 p.m. on the date stated in the written notice or, if later, at 11:59:59 p.m. on the 32nd – 91st day after the Insurer mails or delivers the written notice.

If the Group cancels the coverage under the Policy, cancellation becomes effective at 11:59:59 p.m. on the date the Insurer receives the written notice or, if later, at 11:59:59 p.m. on the date stated on the written notice.

Form 54.1201 ER VT 20120105 SOV Page 1

Statement of Variables

Cancellation does not affect any claim for loss covered under the Policy which occurs during the Insured Person's period of coverage. No benefit is payable for charges incurred after the effective date of cancellation of coverage under the Policy, except as provided in the Policy's benefit provisions.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Cancellation of Policy for Nonpayment of Premiums: The Insurer will notify the Policyholder of any premium payment due at least 21 days before the due date. If the Insurer does not receive payment by the due date, the Insurer will send a termination notice to the Policyholder notifying the Policyholder that the Insurer will terminate the Policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If the Insurer does not receive payment within 14 days from the date of mailing of the termination notice the Insurer may cancel coverage effective on the due date.

Cancellation of Insured Person's Coverage: An Insured Person may cancel coverage by mailing to the Insurer written notice stating the date of cancellation. The effective date of any cancellation is 11:59:59 p.m. on the date stated in the written notice or, if later, 11:59:59 p.m. on the date the Insurer receives the written notice.

Covered Person Requests within a Group: Requests for cancellation from Covered Persons within a Group will only be honored if submitted by the Group to the Administrator.

PREMIUM

Payment: Coverage is provided in return for payment of the required premium. Premiums may be paid daily, weekly, monthly, quarterly, semi-annually, annually, or for a specified term less than one year. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Insured Person takes effect. Premium is payable to the Insurer or one of its authorized agents. If payment of a premium is not honored by the bank or credit card drawn upon, the insurance is deemed to have not been purchased and not to be in effect.

Premium Due Dates: The Insured Person's first premium is due and payable on the Insured Person's Effective Date of Coverage.

Change in Premium: The Insurer may change the premiums due on or after the first Policy Anniversary Date but not more often than once in any 12 month period ← Term may vary based upon the plan specifications. The Insurer shall give written notice of such change at least 31 – 90 days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended. If the Insurer changes rates, the change will apply only to coverage starting on or after the effective date of the change. The Insurer will give the Group at least 31 days advance written notice of any change.

INDIVIDUAL CERTIFICATES

The Insurer will furnish to the Group', for delivery to each Eligible Participant, an individual certificate setting forth in substance the essential features of the insurance coverage of such Eligible Participants and to whom benefits thereunder are payable.

NEW MEMBERS

New Members: Eligible new employees and dependents may be added to the Group Policy, in accordance with the terms of the Policy and the attached Certificate.

INCORPORATION PROVISION

The provisions of the attached Certificate, all endorsements and riders, and all endorsements and riders issued to amend this Policy after its effective date are made a part of this Policy.

This Policy was signed by the Policyholder on the application. The President and Secretary sign below on behalf of BCS Insurance Company.

GROUP INSURANCE POLICY
PROVIDING ACCIDENT AND SICKNESS INSURANCE
Non-participating - Dividends are not payable

HFBLacham, II

Form 54.1201 ER VT 20120105 SOV Page 2

GENERAL STATEMENTS: In no event will variables be less favorable to an insured than the minimum standards set forth in Vermont law.

Blue-faced type is either editing/issuing notations or comments meant to explain how the variable material is to be handled. **Red-faced** type is either illustrative "John Doe" information or the actual variables that will be made available. Numeric variables are shown in **Green** and range from minimum to maximum.

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

Administrative Office: [c/o Authorized Administrator, Address 1, Address 2, City/State/Zip]

[Product Name] HTH Group Insurance Plan

\$0 - \$50,000 Deductible Plan← Included if deductible plan, otherwise deleted.

Major Medical Plan

Certificate of Coverage Number: BCS12345678← Actual certificate number shown here. Effective Date: 01/01/2011← Actual certificate/coverage effective date shown here.

This Plan is a Participating Provider Plan for major medical care.

VII.

VIII.

Under this Plan, 4 Ever Life Insurance Company (Insurer) pays certain benefits at higher payment percentages when the services of a Participating Provider are used.

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit when it is in connection with a Medical Emergency.

Signatures will change as

The Insurance Coverage Area is any place that is within the United States or outside the United States or anywhere in the world. The appropriate phrase will be shown here.

| Pres | ← officers change → sident | Secretary |
|------|--------------------------------|----------------------------------|
| | Table of Contents Actual page | e numbers will be shown √ |
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I. Introduction

About This Plan

This Certificate of Coverage is issued by 4 Ever Life Insurance Company ("Insurer") In this Plan, "Insurer" means the 4 Ever Life Insurance Company. The "Eligible Participant" is the person who meets the eligibility criteria of this Certificate. The term "Insured Person," means the Eligible Participant and any Insured Dependents.

The benefits of this Plan are provided only for those services that the Insurer determines are Medically Necessary and for which the Insured Person has benefits. The fact that a Physician prescribes or orders a service does not, by itself, mean that the service is Medically Necessary or that the service is a Covered Expense. If the Eligible Participant has any questions about whether services are covered, he/she should consult this Certificate of Coverage or telephone the Insurer at the number shown on his/her identification card.

This Certificate of Coverage contains many important terms (such as "Medically Necessary" and "Covered Expense") that are defined in Part III and capitalized throughout the Certificate of Coverage. The Eligible Participant may wish to consult Part III for the meanings of these words as they pertain to this Certificate of Coverage before reading through this Certificate of Coverage.

The Insurer has issued a Policy to the Group identified on the Eligible Participant's identification card. The benefits and services listed in this Certificate of Coverage will be provided for Insured Persons for a covered Illness, Injury, or condition, subject to all of the terms and conditions of the Policy.

Choice of Hospital and Physician: Nothing contained in this Plan restricts or interferes with the Eligible Participant's right to select the Hospital or Physician of the Eligible Participant's choice. Also, nothing in this Plan restricts the Eligible Participant's right to receive, at his/her expense, any treatment not covered in this Plan.

Providers in the U.S.: Covered Expenses for Participating Providers are based on the Insurer's Negotiated Rate. These Participating Providers have agreed to accept the Negotiated Rate as payment in full. Covered Expenses for Non-Participating Providers are based on Reasonable Charges, which may be less than actual billed charges. Non-Participating Providers can bill the Eligible Participant for amounts exceeding Covered Expenses. The Eligible Participant's personal financial cost may be considerably higher when he/she uses a Non-Participating Provider rather than a Participating Provider. *Included if also coverage provided to insureds when in USA.

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.

OVERVIEW MATRIX

| | Limits Outside the U.S. | Limits In Network, U.S. | Limits Out-of-Network, U.S. |
|--|--|---|---|
| MEDICAL EXPENSES references to in | n-network or out of network included if cover per | · | Out-of-Network, 0.5. |
| Deductible Any deductible paid for one column will be applied towards the deductible in another column. | Included if deductible applies→\$0 - \$10,000 per Insured Person per Policy or Calendar Year. Included if family plan→ and limited to \$0 - \$25,000 per Family per Policy or Calendar Year. | Included if deductible applies→\$0 - \$10,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$25,000 per Family per Policy or Calendar Year. ← Included if coverage provided within USA. | Included if deductible applies→\$0 - \$10,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$25,000 per Family per Policy or Calendar Year. ← Included if coverage provided within USA. |
| Payment Level One | Included if coinsurance applies -> Until the Coinsurance Maximum is satisfied, the Insurer will pay 75-100% of the Usual and Customary Fee. | Included if coinsurance applies→Until the Coinsurance Maximum is satisfied, the Insurer will pay 75-100% of the Usual and Customary Fee. ← Included if coverage provided within USA. | Included if coinsurance applies→Until the Coinsurance Maximum is satisfied, the Insurer will pay 75-100% of the Usual and Customary Fee. ← Included if coverage provided within USA. |
| Payment Level Two | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Negotiated Rate. — Included if coverage provided within USA. | Once the Coinsurance Maximum is satisfied the Insurer will pay 100% of the Usual and Customary Fee. Included if coverage provided within USA. |
| Coinsurance Maximum Any Coinsurance paid for one column will be applied towards the deductible in another column. | Included if deductible→\$0 - \$50,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$100,000 per Family per Policy or Calendar Year. | Included if deductible→\$0 - \$50,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$100,000 per Family per Policy or Calendar Year. ← Included if coverage provided within USA. | Included if deductible→\$0 - \$50,000 per Insured Person per Policy or Calendar Year. Included if family plan→and limited to \$0 - \$100,000 per Family per Policy or Calendar Year. ← Included if coverage provided within USA. |
| ACCIDENTAL DEATH AND DISMEMBERMENT | Maximum Benefit: Principal Sun | n up to \$10,000 - \$100,000 ← <i>Include i</i> | AD&D if selected by policyholder. |
| REPATRIATION OF REMAINS | Maximum Benefit up to \$10,000 - \$50,000 ← Included Reparation benefit if selected by policyholder. | | |
| MEDICAL EVACUATION | Maximum Lifetime Benefit for all E | Evacuations up to \$50,000 - \$1,000,000 benefit selected by policyholder. | 0← Included if Medical Evacuation |
| BEDSIDE VISIT | | - \$10,000 for the cost of one economy of the Hospital Confinement for one (1 benefit selected by policyholder. | |

SCHEDULE OF BENEFITS

| Benefits | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. |
|--|---|---|---|
| Preventive Care Services – Deduct | ible is not applicable | | |
| For Dependent Children (Birth to Age 19) | 100% of the actual charges | 100% of the Negotiated Rate | All except a \$0 - \$100 Copayment / Overview Matrix, Payment Level 1 and/or Payment Level 2 |
| For Adults (Age 20 and Older) | 100% of the actual charges | 100% of the Negotiated Rate | All except a \$0 - \$100 Copayment / Overview Matrix, Payment Level 1 and/or Payment Level 2 |
| Services Provided by a Physician of applicable Shown if deductible does | or Provider – Copayments and Deduces not apply. | ctible applies ← Shown if deductible ap | oplies. Deductible is not |
| Surgical Care | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Medical Care | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Emergency Care | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Physician Office Visits | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | All except a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Other Physician services | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 |
| Annual Physical Examination/Health screening for services not covered by Preventative Care ← Include if selected by policyholder | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$500 - \$1,000 and limited to one per Policy or Calendar Year. | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$500 - \$1,000 and limited to one per Policy or Calendar Year. | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$500 - \$1,000 and limited to one per Policy or Calendar Year. |
| Travel Vaccinations/Immunizations not covered under Preventative Care Services ← Include if selected by policyholder. | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$200 - \$500 per Policy or Calendar Year. Shown if policy or calendar year max applies. | After a \$0 - \$100 Copayment, Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$200 - \$500 per Policy or Calendar Year. Shown if policy or calendar year max applies. | After a \$0 - \$100 Copayment, ← Shown if co-payment applies. Overview Matrix, Payment Level 1 and/or and Payment Level 2 up to a Maximum of \$200 - \$500 per Policy or Calendar Year. ← Shown if policy or calendar year max applies. |
| Services and Supplies Provided by | a Hospital – Copayments and Dedu | ctible apply if applicable | |
| Inpatient Hospital Care | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |

| Benefits | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. |
|---|--|--|--|
| Outpatient Hospital Care | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Emergency Care ¹ | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Other Services and Special Condition if Deductible does not apply | ions – Copayments <mark>and Deductible</mark> a | pply. ← Show if Deductible applies. D | eductible is not applicable. ← Show |
| Ambulance Transportation | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Ambulatory Surgical Facility | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Autism Spectrum Disorders | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Dental Care for an Accidental Injury | | % of Covered Expenses up to \$50 – \$ tooth limit applies -> and limited to \$50 | |
| Maternity | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Mental Illnesses | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Chiropractic Care | Included if copayment applies After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2 and limited to 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2 and limited to 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2 and limited to 6 – 50 visits per Policy or Calendar Year. |
| Physical/Occupational Therapy/Medicine | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2, and as many as 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2, and as many as 6 – 50 visits per Policy or Calendar Year. | Included if copayment applies→ After a \$0 - \$100 Copayment and/or Overview Matrix, Payment Level 1 and/or and Payment Level 2, and as many as 6 – 50 visits per Policy or Calendar Year. |
| Human Organ Transplants | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Infertility Treatment ← Included if selected by policyholder. | Limited to \$25,000 - \$100,000 per lifetime | Limited to \$25,000 - \$100,000 per lifetime | Limited to \$25,000 - \$100,000 per lifetime |
| Home Health Care ← Mandated offer; include if selected by policyholder. | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, <i>Include if per visit max applies</i> -> up to a maximum of 10 – 180 visits per Policy <i>or</i> Calendar Year |
| Skilled Nursing Facilities | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, Include if per visit max applies → up to a maximum of 10 – 180 visits per Policy or Calendar Year | Overview Matrix, Payment Level 1 and/or and Payment Level 2, <i>Include if per visit max applies</i> —> up to a maximum of 10 – 180 visits per Policy <i>or</i> Calendar Year |
| Hospice← Included if selected by policyholder. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. | Overview Matrix, Payment Level 1 and/or and Payment Level 2. |
| Pharmacy Benefits← Included | Pharmacy Benefits if selected by police | syholder. | |

| Benefits | Outside the U.S. | In Network, U.S. | Out-of-Network, U.S. |
|---|---|------------------|----------------------|
| Pharmacy – Outside the US Maximum 30 – 180 day supply | 100%> of actual charge / the Copayment stated below | | |
| Prescription Drugs | All except a \$5 - \$30 Copayment per prescription, per 30 day supply | | |
| 2. Injectables | All except a 10% - 30% Copayment per Prescription, per 30 day supply | | |
| Pharmacy – Inside the US Maximum 30 – 180 day supply | 50% - 100% of actual charge / the Copayment stated below | | |
| Generic Drugs | All except a \$5 - \$30 Copayment per prescription, per 30 day supply | | |
| 2. Brand name Drugs | All except a \$5 - \$30 Copayment per prescription, per 30 day supply | | |
| 3. Injectables | All except a 10% - 30% Copayment per Prescription, per 30 day supply | | |

| Hearing Services | No Deductible. 50% - 100% of Covered Expenses per Policy <i>or</i> Calendar Year up to a maximum of \$250 -\$1,000 for Hearing Services that are not the result of an Injury or Illness. ← <i>Include if elected by the policyholder</i> . In addition, for a Covered Person who is a Dependent Child under age 24. No Deductible. 50% - 100% of Covered Expenses up to a maximum of \$1,000 per Hearing Aid every three years. ← <i>Include if dependent children covered</i> . |
|--|--|
| Vision Care ← Include Vision Care if selected by policyholder. | No Deductible. 50% - 100% of Covered Expenses per Policy <i>or</i> Calendar Year up to a maximum of \$250 -\$1,000 for Vision Care that is not the result of an Injury or Illness. |
| Dental Care ← Include Dental Care if selected by policyholder. | Subject to a maximum Covered Expenses of \$500 - \$3,000 per Policy or Calendar Year. |
| Preventive Dental Services | 100% of Actual Cost |
| Primary Dental Services | 100% - 50% of Actual Cost |
| · · · · · · · · · · · · · · · · · · · | 10070 3070 61716tdd1 003t |
| , | 100% - 50% of Actual Cost |
| Major Dental Services | |

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

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 an employee, 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 Employee

An Eligible Employee means a permanent full time employee or trainee, who usually works at least 20 – 40 hours a week in the conduct of the Group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis. *Included if eligible according to employer requirements and permitted by state.* An Eligible Employee does not include an employee who works on a part-time, temporary, or substitute basis. *or* An Eligible Employee may be a consultant or contractor engaged by the Group in the conduct of its business and works in the conduct of the Group's business at least 20 – 40 hours a week. *Included if eligible according to employer requirements and permitted by state.* An Eligible Employee also includes officers and directors of the Group regardless of the number of hours a week devoted to the conduct of the Group's business. *Included or deleted by agreement between the policyholder and the company.* An Eligible employee resides outside his/her Home Country and is scheduled to reside outside his/her Home Country for a period greater than 3 – 24 months.

If two members of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Group, then each must enroll separately as an Insured Participant. — *Included or deleted by agreement between the policyholder and the company.*

Eligible Dependents ← Include this entire provision if dependents covered.

An Eligible Dependent means a person who is the Eligible Participant's:

- 1. spouse or civil union partner or domestic partner; Spouse and civil union partner included if dependents covered; domestic partner included if selected by the policyholder.
- 2. natural child, stepchild or legally adopted child who has not yet reached age 26 and includes dependents of a civil union or domestic partnership. Shown if domestic partnership coverage elected by policyholder,
- 3. own or spouse's or civil union partner's or domestic partner's ← Shown if domestic partnership coverage elected by policyholder. 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. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal quardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

As used above: ← Spouse and civil union partner included if dependents covered; domestic partner if selected by policyholder; combination of items 3a-f and 4a-g included based on state requirements for domestic partner and by agreement between the policyholder and the company; items 5 and 6 always included. ◆

- 1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
- 2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
- 3. The term "domestic partner" means a person of the same or opposite ← Shown if elected by policyholder, sex who:
 - a. is not married or legally separated;
 - b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
 - c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months:
 - d. occupies the same residence as the Eligible Participant;
 - e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
- f. as entered into a domestic partnership arrangement with the named Insured. \leftarrow Provision 3 in its entirety will not be shown if domestic partner coverage not elected by policyholder.
- 4. The term "domestic partnership arrangement means the Eligible Participant and another person of the same or opposite Shown if elected by policyholder. sex has any three of the following in common:
 - a. joint lease, mortgage or deed;
 - b. joint ownership of a vehicle:
 - c. joint ownership of a checking account or credit account;

- d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
- e. designation of the domestic partner as a beneficiary of the employee's will;
- f. designation of the domestic partner as holding power of attorney for health care; or
- 5. The term "civil union partner" means a person with whom the Eligible Participant has entered into a civil union in accordance with Vermont law.
- 6. The term "civil union" means that two eligible persons have established a relationship pursuant to Vermont Statute, Title 15, Chapter 23 and are thereby entitled to receive the benefits and protections and be subject to the responsibilities of spouses.

A person may not be an Insured Dependent for more than one Insured Participant.

Additional Requirements for an Eligible Participant and Eligible Dependents

Included if dependents covered.: An Eligible Participant or an Eligible Dependent

Included if dependents covered. The Eligible Dependents Covered. The

- 1. Citizen of the U.S. or permanent resident of the U.S. (as defined by the immigration code of the U.S.)
- 2. Employed by a company with offices in the U.S.
- 3. not a resident of the U.S.
- 4. his/her Home Country is not the U.S.
- 5. under Age 60 85.
- 6. enrolled in a Primary Plan.
- 7. Country of Assignment is other than the Eligible Participant's Home Country.
- ↑ Some combination of 1–7 by agreement between the policyholder and the company.

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. Applications will be accepted up to 30 days after the Initial Eligibility Date, however, —Included by agreement between the policyholder and the company. 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. <u>Newborn Children:</u> 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. *Included if dependents covered.*
 - 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 civil union partner or domestic partner ← Included if domestic partners covered. 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. ← Included if dependents covered.
 - c. <u>Adopted Children:</u> 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. Included if dependents covered.
 - 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. Included if dependents covered.
- 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.

Special Enrollment Periods ← Included or deleted this entire provision based on employer needs and consistency with other insurance programs in effect.

- 1. Eligible Participants who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they have other coverage may do so within 31 days after that other coverage terminates if the following requirements are met:
 - a. If the other coverage was COBRA continuation under another plan, that continuation must have been exhausted before the Eligible Participant may enroll the affected persons under this Plan.
 - b. If the other coverage was not COBRA continuation, then any employer contribution toward the cost of the coverage must have terminated or that coverage must itself have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:
 - i. legal separation or divorce;
 - ii. death:
 - ii. termination of employment or reduction in hours of employment.

The Eligible Participant must have declined enrollment for employee and/or dependent coverage during the Initial Enrollment Period by means of a written statement that the reason for declining enrollment was other coverage.

- 2. An Eligible Participant who did not enroll during the Initial Enrollment Period may enroll for participant and/or dependent coverage within 31 days after he or she marries or acquires an Eligible Dependent Child or Children by birth, adoption, or placement for adoption.
- 3. An Eligible Participant who did not enroll his or her spouse or civil union partner or domestic partner *Included if domestic partners covered.* during an Initial Enrollment Period may enroll that spouse within 31 days after the Eligible Participant acquires such new Dependent.

If an Eligible Participant does not apply within the 31 days of the Initial Enrollment Period or within the 31 days of a Special Enrollment Period as outlined above, he/she will become a Late Enrollee.

How Coverage Ends

Insured Participants

The Insured Participant's coverage ends without notice from the Insurer on the earlier of:

- 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 Eligible Person leaves the Country of Assignment for his/her or her Home Country;
- 4. the date the Policy terminates;
- 5. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision.

Insured Dependents

The Eligible Participant's insured Dependent's coverage will end on the earlier of:

- 1. the date the Insured Participant's Insured Dependent no longer meets the definition of an Eligible Dependent as defined in the Plan;
- 2. the end of the period for which premium payment has been made to the Insurer;
- 3. the date the Policy terminates;
- 4. the date the Insured Participant's coverage terminates;
- 5. the date of fraud or misrepresentation of material fact by the Insured Dependent, except as indicated in the Time Limit on Certain Defenses provision. Included if dependents covered.

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.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this Certificate or as specified below when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

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:
- on any premium due date for any of the following reasons. The Insurer must give the Group written notice of at least 30 days in advance if termination is due to:
 - a. failure to maintain the required minimum premium contribution;
 - b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
 - c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.
- 4. on any premium due date if the Insurer is also canceling all Group Health Benefit Plans in the state or in a geographic Service Area. The Insurer must give the Group written notice of cancellation:
 - a. at least 180 days in advance; and
 - 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.

Continuation (COBRA)

Most employers in the United States who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law, which governs this provision the Insured Participant may also be entitled to a period of continuation of coverage under this Act. The Insured Participant should check with his/her employer for details.

III. Definitions

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Certificate, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter that means that the term is also defined in these definitions. All definitions have been arranged in **ALPHABETICAL ORDER**.

Accidental Injury means an accidental bodily Injury sustained by an Insured Person, which is the direct cause of a loss which is not the result of disease, bodily infirmity.

Acupuncture means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body.

Advanced Practice Nurse means a duly licensed Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

Age means the Insured Person's attained age.

Aggregate Annual Benefit Maximum means the maximum amount of benefits to which you are annually entitled under the program for all covered services combined.

Alcoholism means a disorder characterized by a pathological pattern of alcohol use that causes a serious impairment in social or occupational functioning, also termed alcohol abuse or, if tolerance or withdrawal is present, alcohol dependence.

Ambulance Transportation means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed. Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

Ambulatory Surgical Facility means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Anesthesia Services means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist that may be legally rendered by them respectively.

Annual Open Enrollment Period is the 31-day period ending each Calendar Year on the anniversary of the Policy's Effective Date.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorized Administrator means a company appointed by the Insurer to administer or deliver benefits listed in this Certificate

Autism Services Provider means any licensed or certified person providing treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder and Asperger's disorder. Diagnosis of Autism Spectrum Disorders means medically necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other testing to determine whether an individual has one or more Autism Spectrum Disorders. For purposes of this definition, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a licensed Physician or by Psychologist if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing.

Benefit Period means the valid dates as shown in the Schedule of Benefits.

A Calendar Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

Certificate means this booklet, the Schedule of Benefits, including your application for coverage under the THE INSURER benefit program described in this booklet.

Certificate of Credible Coverage means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

Certified Nurse Midwife means a nurse-midwife who (a) practices according to the standards of the appropriate local licensing authority; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- 1. is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- 2. is a graduate of a program of nurse-midwives accredited by the appropriate local licensing authority.

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs. Includes medically-necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Chiropractor means a duly licensed chiropractor.

Claim means notification in a form acceptable to THE INSURER that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which THE INSURER may request in connection with services rendered to you.

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.")

Claim Payment means the benefit payment calculated by THE INSURER, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.")

Clinical Laboratory means a clinical laboratory that complies with the licensing and certification requirements under the applicable federal, state and local laws.

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

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 {Policy/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 or are caused by the pregnancy, such as acute nephritis, nephrosis, cardiac decompression, missed abortion, 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 false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

A **Continuing Hospital Confinement** means consecutive days of in-hospital service received as an inpatient, or successive confinements for the same diagnosis, when discharge from and readmission to the Hospital occurs within 24 hours.

Coordinated Home Care means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Copayment is the dollar amount of Covered Expenses the Insured Person is responsible for paying. Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expenses.

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Country of Assignment means the country for which the Eligible Participant has a valid 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.

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Expenses are the expenses incurred for Covered Services. Covered Expenses for Covered Services received from Participating Providers will not exceed the Negotiated Rate. Included if PPO plan. Covered Expenses for Covered Services received from Non-Participating and/or and Foreign Country Providers or any provider Appropriate phrase will be shown. will not exceed Reasonable Charges. In addition, Covered Expenses may be limited by other specific maximums described in this Plan in the Overview Matrix, the Schedule of Benefits, under section IV, How the Plan Works and section V, Benefits - What the Plan Pays. Covered Expenses are subject to applicable Deductibles, penalties and other benefit limits. An expense is incurred on the date the Insured Person receives the service or supply.

Covered Person means the Insured, and any Eligible Dependents.

Covered Services are Medically Necessary services or supplies that are listed in the benefit sections of this Plan, and for which the Insured Person is entitled to receive benefits.

Creditable Coverage means coverage you had under any of the following:

- 1. A group health plan;
- 2. Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;
- 3. Medicare (Part A or B of Title XVIII of the Social Security Act);
- 4. Medicaid (Title XIX of the Social Security Act);
- 5. CHAMPUS (Title 10 U. S. C. Chapter 55);
- 6. The Indian Health Service or a tribal organization;
- 7. A State health benefits risk pool;
- 8. The Federal Employees Health Benefits Program;
- 9. A public health plan maintained by a State, county or other political subdivision of a State;
- 10. Section 5(e) of the Peace Corps Act.

Custodial Care Service means those services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the health care facility involved.

Deductible means the amount of Covered Expenses the Insured Person must pay for Covered Services before benefits are available to him/her under this Plan. The **Annual Deductible** is the amount of Covered Expenses the Eligible Participant must pay for each Insured Person before any benefits are available regardless of provider type.

Dental Prosthesis means prosthetic services including dentures, crowns, caps, bridges, clasps, habit appliances, partials, inlays and implants services, as well as all necessary treatments including laboratory and materials.

Dentist means a duly licensed dentist.

Doctor of Acupuncture means a person licensed to practice the art of healing known as acupuncture.

Diagnostic Service means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Dialysis Facility means a facility (other than a Hospital) whose primary function is the treatment and/ or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

The **Effective Date of the Policy** is the date that the Group's Policy became active with the Insurer.

The Effective Date of Coverage is the date on which coverage under this Plan begins for the Eligible Participant and any other Insured Person.

Eligible Charge means (a) in the case of a Provider other than a Professional Provider which has a written agreement with a Plan and/or our Authorized Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with a Plan and/or our Authorized Administrator to provide care to you at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of a Plan and/or our Authorized Administrator:

- 1. the charge which the particular Hospital or facility usually charges its patients for Covered Services, or
- 2. the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by a Plan and/or our Authorized Administrator.

Eligible Dependent (See 'Eligibility Rules' in Section II of this Plan)

Eligible Participant (See 'Eligibility Rules' in Section II of this Plan)

Eligible Person means an employee of the Group who meets the eligibility requirements for this health and/or dental and/or medical evacuation and repatriation coverage, as described in the Eligibility Section of this Certificate.

Emergency (See Emergency Medical Care)

Emergency Accident Care means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

Emergency Medical Care means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- 1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- 2. serious impairment to bodily functions; or
- 3. serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Mental Illness Admission means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Experimental / Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the final determination as to what is experimental or investigational.

Facility means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Family Coverage means coverage for you and your eligible dependent(s) under this Certificate.

Foreign Country is any country that is not the Insured Person's Home Country.

Foreign Country Provider is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America. A Foreign Country Provider may also be a supplier of medical equipment, drugs, or medications. HTH provides Insured Persons with access to a database of Foreign Country Providers with whom it has made arrangements for accepting assignment of benefits and direct payments of Covered Expenses on behalf of the Insured Person.

Group refers to the business entity to which the Insurer has issued the Policy.

Group Administrator means the administrator assigned by your Group to respond to your inquiries about this coverage. The Group Administrator is not the agent of THE INSURER.

Group health insurance coverage means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

Group health plan means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise

- 1. "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- 2. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- 3. "Health benefit plan" does not include:
 - a. Coverage only for accident, or disability income insurance, or any combination thereof;
 - b. Coverage issued as a supplement to liability insurance;
 - c. Liability insurance, including general liability insurance and automobile liability insurance;
 - d. Workers' compensation or similar insurance;
 - e. Automobile medical payment insurance;
 - f. Credit-only insurance;
 - g. Coverage for on-site medical clinics; and
 - h. Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- 4. "Health benefit plan" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - a. Limited scope dental or vision benefits;
 - b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - c. Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- 5. "Health benefit plan" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - a. Coverage only for a specified disease or illness; or
 - b. Hospital indemnity or other fixed indemnity insurance.
- 6. "Health benefit plan" shall not include the following if offered as a separate policy, certificate or contract of insurance:
 - a. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - c. Similar supplemental coverage provided to coverage under a group health plan.

Group Policy or Policy means the agreement between THE INSURER and the Group, any riders, this Certificate, the Schedule of Benefits, the Benefit Program Application and any employee application form of the persons covered under the Policy.

Habilitative Care or Rehabilitative Care means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals the provider has identified.

Hearing Aids means any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.

Home Country means the Insured Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.

Home Health Agencies and Visiting Nurse Associations are home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Eligible Participant's home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospices are providers that are licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as a hospice provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospital means any establishment that is licensed in the country where it operates and where the medical practitioner permanently supervises the patient. The following establishments are not considered as hospitals: rest and nursing homes, spas, cure-centers, and health resorts.

HTH means Highway to Health (d/b/a HTH Worldwide). This is the entity that provides the Insured Person with access to online databases of travel, health, and security information and online information about physicians and other medical providers outside the U.S.

An **Illness** is a sickness or disease of an Insured Person, which first manifests itself after the Insured Person's Effective Date and while coverage is in force.

Individual Coverage means coverage under this Certificate for yourself but not your spouse or civil union partner or domestic partner — Included if domestic partners covered. and/or eliqible dependent children.

Infertility means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one year.

Infusion Therapy is the administration of Drugs (prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

Initial Eligibility Date is the Effective Date for a participant who becomes eligible after the Effective Date of the Policy.

Initial Enrollment Period is the 31 day period during which an Eligible 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)

Inpatient means that you are a registered bed patient and are treated as such in a health care facility.

Insurance Coverage Area is the primary geographical region in which coverage is provided to the Insured Person.

Insured Dependents are members of the Eliqible Participant's family who are eliqible and have been accepted by the Insurer under this Plan.

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Plan.

Insured Person means both the Insured Participant and all other Insured Dependents who are covered under this Plan.

The Insurer means 4 Ever Life Insurance Company that is a nationally licensed and regulated insurance company.

Investigative Procedures (See Experimental/Investigational).

Investigational or Investigational Services and Supplies means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the appropriate government agency at the time used or administered to you.

A Late Enrollee means any Eligible Participant or Eligible Dependent who submits his/her written application after the expiration of the Initial Enrollment Period or the Special Enrollment Period.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maternity Service means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy that, through vaginal delivery, results in an infant, who weighs *5* pounds or more.

Maximum Allowance means the amount determined by a Plan that Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers in the United States of America will be based on the Schedule of Maximum Allowances. A Plan may amend these amounts from time to time.

Medical Care means the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including the transportation primarily for and essential to medical care referred to in Paragraph

Medically Necessary (See exclusions section of this certificate)

Mental Health Care Professional means any person, corporation, facility or institution certified or licensed by this state to provide mental health care services, including but not limited to a physician, a nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such provider acting in the course and scope of employment or an agency related to mental health care services.

Mental Health Review Agent means a person or entity performing service review activities who is either affiliated with, under contract with, or acting on behalf of a business entity in the state of Vermont; or a third party who provides or administers mental health care benefits to citizens of Vermont, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care Physicians to coordinate delivery of services, authorized to offer health insurance policies or contracts in Vermont.

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient, or as approved by the Authorized Administrator. Mental Illness will also include Substance Abuse and the following biologically-based mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- 1. schizophrenia;
- 2. bipolar disorder;
- 3. obsessive-compulsive disorder;
- 4. major depressive disorder;
- 5. panic disorder;
- 6. anorexia nervosa;
- 7. bulimia nervosa;
- 8. schizo-affective disorder; and
- 9. delusional disorder.

Negotiated Rate is the rate of payment that the Insurer has negotiated with a Participating Provider for Covered Services.

Network means the group of participating providers providing services to a managed care plan

A Newborn is a recently born infant within 31 days of birth.

Non-Participating Hospital (out of network) is a Hospital that has not entered into a Participating Hospital agreement with the Insurer at the time services are rendered.

A Non-Participating Physician (out of network) is a Physician who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-Participating Provider (out of network) is a provider who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-U.S. Resident means an expatriate who is a U.S. Citizen or third country national residing outside of the United States.

Nursing at Home means physician prescribed Skilled Nursing Service at your residence immediately after or instead of inpatient or outpatient care treatment.

Nursing at Home Care Program means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Occupational Therapist means a duly licensed occupational therapist.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

- 1. History (gathering of information on an Illness or Injury).
- 2. Examination.

3. Medical Decision Making (the Physician's diagnosis and Plan of treatment). This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

Optometrist means a duly licensed optometrist.

Other Plan is an insurance plan other than this plan that provides medical, repatriation of remains, and/or medical evacuation benefits for the Insured Person.

Outpatient means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Partial Hospitalization Treatment Program means a planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

A **Participating Hospital** (in network) is a Hospital that has a Participating Hospital agreement in effect with the Insurer at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Participating Physician (in network) is a Physician who has a Participating Physician agreement in effect with the Insurer at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for Covered Services.

A **Participating Provider** (in network) is a Participating Physician, hospital, or other health care provider that has a Participating Provider agreement in effect with the Insurer at the time services are rendered. Participating Providers agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Pediatric Preventative Care means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a physician and rendered to a child.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Physical Therapist means a duly licensed physical therapist.

Physical Therapy means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician or Doctor means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits. Includes a licensed naturopathic physician working within the scope of his or license providing covered services or treatment.

Plan is the set of benefits described in the Certificate of Coverage booklet and in the amendments to this booklet (if any). This Plan is subject to the terms and conditions of the Policy the Insurer has issued to the Group. If changes are made to the Policy or Plan, an amendment or revised booklet will be issued to the Group for distribution to each Insured Participant affected by the change.

Podiatrist means a duly licensed podiatrist.

Policy is the Group Policy the Insurer has issued to the Group.

Preexisting Condition means any condition for which medical advice or treatment was recommended by or received from a Physician within 6 months prior to the Coverage Date for the insured.

A **Primary Plan** is a Group Health Benefit Plan, an individual health benefit plan, or a governmental health plan designed to be the first payor of claims for an Insured Person prior to the responsibility of this Plan.

Private Duty Nursing Service means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse that is not providing this service as an employee or agent of a Hospital or other health care facility. Private Duty Nursing Service does not include Custodial Care Service.

Provider or Professional Provider means any health care facility (for example, a Hospital) or person (for example, a Physician, Dentist, Podiatrist, Psychologist, or Chiropractor) or entity duly licensed to render Covered Services to you.

Psychologist means a Registered Clinical Psychologist.

A **Reasonable Charge**, as determined by the Insurer, is the amount it will consider a Covered Expense with respect to charges made by a Physician, facility or other supplier for Covered Services. In determining whether a charge is Reasonable, the Insurer will consider all of the following factors:

- 1. The actual charge.
- 2. Specialty training, work value factors, practice costs, regional geographic factors and inflation factors.
- 3. The amount charged for the same or comparable services or supplies in the same region or in other parts of the country.
- 4. Consideration of new procedures, services or supplies in comparison to commonly used procedures, services or supplies.
- 5. The Average Wholesale Price for Pharmaceuticals.

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

Registered Clinical Psychologist means a Clinical Psychologist who is registered with a department of professional regulation or, in a state or country where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state or country where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

- 1. has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or
- 2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

Renal Dialysis Treatment means one unit of service including the equipment, supplies and administrative service that are customarily considered as necessary to perform the dialysis process.

Schedule of Benefits means the document attached to the Certificate showing the coverage and benefit amounts provided under your Group Policy.

Skilled Nursing Facility means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensee by the appropriate governmental authority to provide such services. This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

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.

Speech Therapist means a duly licensed speech therapist.

Speech Therapy means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psycho-social speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Substance Abuse Rehabilitation Treatment means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, or Clinical Professional Counselor, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment,

Surgery means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by our Authorized Administrator.

Temporomandibular Joint Dysfunction & Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Therapeutic Care means services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers for the Treatment of Autism Spectrum Disorders.

Totally Disabled means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Treatment of Autism Spectrum Disorders means the following care prescribed, provided, or ordered for an individual diagnosed with one or more autism spectrum disorders by a licensed Physician or a licensed psychologist if such physician or psychologist determines the care to be medically necessary:

- 1. Habilitative Care or Rehabilitative Care;
- 2. pharmacy care;
- psychiatric care:
- 4. psychological care; and
- Therapeutic Care.

Usual & Customary (or U&C) Fee means the fee as reasonably determined by a Plan and/or our Authorized Administrator, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor, or Optometrist ("Professional Provider") who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Psychologists, Clinical Social Workers, Chiropractors, or Optometrists ("Professional Providers") of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

However, if a Plan and/or our Authorized Administrator reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by a Plan and/or our Authorized Administrator.

U.S. means the United States of America.

IV. How the Plan Works

The Insured Person's Plan pays a portion of his/her Covered Expenses after he/she meets his/her Deductible each Policy or Calendar Year. This section describes the Deductible and Copayments Show if Copayments apply. 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. — *Included if PPO involved.*

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.

Included if PPO involved.

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. — Included if PPO not involved.

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 *or* Calendar Year. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received from either Participating or Non-Participating Providers each Policy *or* Calendar Year before any benefits are available. The Annual Deductible does not apply to those Office Visits for which a Copayment is required. Annual maximum Deductibles (if any) for the Insured Eligible Participant and his/her Eligible Dependents is stated in the Overview Matrix.

Coinsurance Maximums

The Coinsurance Maximum is the amount of Copayment each Insured Person incurs for Covered Expenses in a Policy or Calendar Year. The Coinsurance Maximum does not include any amounts in excess of Covered Expenses, Prescription Drug Deductible or Copayments, Annual Deductible, amounts applied to any penalties, or any amounts in excess of other benefit limits of this Plan.

The in network (Participating Providers) Coinsurance Maximum per Insured Person per Policy or Calendar Year is as stated in the Overview Matrix.

The **out-of-network** (Non-Participating Providers) Coinsurance Maximum per Insured Person per **Policy** *or* **Calendar** Year is as stated in the Overview Matrix.

Once the **in network** (Participating Providers) Coinsurance Maximum is met, the Insurer will pay the percentage of Reasonable Charges for Non-Participating Providers for the remainder of the Policy *or* Calendar Year as stated in the Overview Matrix.

Once the **out of network** (Non-Participating Provider) Coinsurance Maximum is met, the Insurer will pay the percentage of Reasonable Charges for Non-Participating Providers for the remainder of the Policy or Calendar Year as stated in the Overview Matrix.

In addition, if an Insured Participant has any Insured Dependents, once the Insured Participant and the Insured Dependents reach a the combined total of Coinsurance expenses from a Participating Provider (in network) as stated in the Overview Matrix, the Insurer will pay the percentage of the Negotiated Rate for Participating Providers for the remainder of the Policy or Calendar Year as stated in the Overview Matrix.

Plan Payment

After the Insured Participant satisfies any required Deductible, payment of Covered Expenses is provided as defined below:

First Level Payment

Until an Insured Persons satisfies his/her in network or out of network Coinsurance Maximum in a Policy or Calendar Year, the Insurer pays:

- 1. The balance of the Covered Expense after the Insured Person pays the Copayment for Office Visits to Participating Providers as stated in the Overview Matrix. The number of visits per Policy or Calendar Year for which the Insurer will pay is limited as stated in the Overview Matrix.
- 2. The percentage of Covered Expenses as stated in the Overview Matrix for routine pap smears and annual mammograms obtained from either a Participating or Non-Participating Provider.
- 3. The percentage of Covered Expense for Office Visits to Non-Participating Providers as stated in the Overview Matrix.
- 4. The percentage of Covered Expense for all other Covered Services obtained from a Participating Provider as stated in the Overview Matrix. The Insured Person pays the balance of the Covered Expense. Participating Providers will not charge more than the Negotiated Rate.
- 5. The percentage of Covered Expense for all other Covered Services obtained from a Non-Participating Provider. The Insured Person pays the balance of the Covered Expense, plus any amount in excess of the Covered Expense.

Second Level Payment

Once an Insured Person satisfies his/her in network (Participating Provider) Coinsurance Maximum in a Policy or Calendar Year, the Insurer pays:

- 1. The percentage of the Negotiated Rate as stated in the Overview Matrix for all other Covered Expenses obtained from a Participating Provider.
- 2. The percentage of the Reasonable Charge as stated in the Overview Matrix for Covered Expenses for routine pap smears and annual mammograms obtained from a Non Participating Provider.
- 3. The percentage of the Reasonable Charges as stated in the Overview Matrix for all other Covered Expenses obtained from a Non-Participating Provider.

Note that there are special limits on Covered Expenses for the following services as described in Section V (See Schedule of Benefits):

Please note any additional limits on the maximum amount of Covered Expenses in the Schedule of Benefits and the discussions of each specific benefit.

V. Benefits: What the Plan Pays

Before this Participating Provider — Include if PPO plan. 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 the Overview Matrix and the Schedule of Benefits.

Following is a general description of the supplies and services for which the Insured Person's Participating Provider Include if PPO plan. Plan will pay benefits, if such supplies and services are Medically Necessary. Whenever the term "you or your" is used, it is meant to mean all eligible Insured Person's as described in described under the Eligibility Section of this document.

Preventive Care Services

Benefits will be provided for preventive care services rendered to an Insured Person, even though they are not ill. Services described below received while outside the United States or inside the United States at an in-network provider will not be subject to a deductible, co-payment or co-insurance. Benefits will be limited to the following services:

Coverage for Preventative Items and Services

- 1. Except as otherwise provided in Subsection 2 below, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved:
 - a. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
 - b. With respect to infants, children and adolescents, evidence-informed preventive care, and screenings, including hearing loss screenings, provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - c. With respect to women, to the extent not described in Subsection 1.a., evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- 2. The Insurer is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection 1 after the recommendation or guideline is no longer described in Subsection 1.
 - a. The Insurer will give sixty (60) days advance notice to the Eligible Participant before any material modification to the services in Subsection 1 become effective.

Additional Benefits Provided: Benefits will be limited to the following services:

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes. Benefits will be provided if these services are prescribed by a health care professional legally authorized to prescribe such training and education under law and rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management.

Benefits for such health care professionals will be provided at the same benefit levels as those provided for any other covered condition.

Diabetes Equipment and Supplies

Benefits are also available for diabetes equipment and supplies prescribed by a health care professional legally authorized to prescribe such equipment and supplies under law for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes.

Benefits for such equipment and supplies will be provided at the same benefit levels as those provided for any other covered condition

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or Pap smear test for females aged 18 and older.

Mammograms

- 1. a baseline mammogram for asymptomatic women at least 35 years of age;
- 2. a mammogram every 1 to 2 years for asymptomatic women age 40 to 50, but no sooner than 2 years after a baseline mammogram;
- 3. a mammogram every year for asymptomatic women age 50 and over.

Benefits will also be provided for any woman when a Physician's evaluation of a woman's physical conditions, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

Prostate Test and Digital Rectal Examination Benefits will be provided for routine prostate-specific antigen tests and digital rectal examinations in accordance with American Cancer Society guidelines.

Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening for persons 50 years of age or older. Screening includes:

- 1. An annual fecal occult blood tests (3 specimens).
- 2. A flexible sigmoidoscopy every 5 years.
- 3. A colonoscopy every 10 years.
- 4. A double contrast barium enema every 5 years.

In addition, benefits will be provided for people who are considered to be high risk for colon cancer because of:

- 1. Family history of familial adenomatous polyposis;
- 2. Family history of hereditary nonpolyposis colon cancer;
- 3. Chronic inflammatory bowel disease;
- 4. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- 5. A background, ethnicity or lifestyle is determined to be at elevated risk.

Annual Physical Examination/Health Screening

An Annual Physical Examination or Health Screening for services not covered under the Preventive Care Services above included in the coverage according to the limits stated in the Schedule of Benefits.

Included if selected by policyholder.

Travel Vaccinations/Immunizations

Recommended travel vaccinations/immunizations not covered under the Preventative Care Services above are covered according to the limits stated in the Schedule of Benefits. — *Included if selected by policyholder*.

Services Provided by a Physician

Surgery

Benefits are available for Surgery performed by a Physician or Dentist. However, for services performed by a Dentist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

- 1. surgical removal of complete bony impacted teeth: \(\subsection Included if selected by policyholder. \)
- 2. excisions of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- 4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, sali-vary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

- 1. Anesthesia Services if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.
- 2. Assistant Surgeon that is, a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

After your Copayment, — *Included if copayment applies.* benefits for Surgery will be provided at the percent level shown in the Schedule of Benefits.

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at the percentage of the Claim Charge as shown in the Schedule of Benefits. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

After your Copayment, — *Included if copayment applies.* benefits for Additional Surgical Opinion will be provided at the percent level shown in the Schedule of Benefits.

Medical Care

Benefits are available for Medical Care visits when:

- 1. you are an Inpatient in a Hospital or Substance Abuse Treatment Facility; or
- 2. you are a patient in a Partial Hospitalization Treatment Program; or
- 3. you visit your Physician's office or your Physician comes to your home.
- 4. After any Copayment, Medical Care Benefits are provided at the percent shown in the Schedule of Benefits.

Other Physician Services

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the **Other Services and Special Conditions** section of this Certificate.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Chemotherapy

The treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents. Your coverage also includes benefits for Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits. \(\leftarrow Included or deleted. \)

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will be provided as shown in the Schedule of Benefits. Included or deleted.

Radiation Therapy Treatments

The treatment of disease by X-ray, radium, or radioactive isotopes.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association or similar body. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits will be provided as shown in the Schedule of Benefits. \(\lefta \) Included or deleted.

Diagnostic Service

Benefits will be provided for those services related to covered Surgery or Medical Care.

Benefit Payment for other Physician Services

After your Copayment, ← Included if copayment applies. benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits when you receive any of the Covered Services described in this Physician Benefit Section from a Provider or from a Dentist.

Emergency Accident or Medical Care

Treatment must occur within 72 hours of the accident.

Benefit Payment for Emergency Accident or Medical Care

After your Copayment, — *Included if copayment applies*. benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits.

Services and Supplies Provided by a Hospital

Inpatient Care

The following are Covered Services when the Insured Person receives them as an Inpatient in a Hospital. Whenever the Insured Person's Physician recommends a non-emergency or non-maternity Inpatient Hospital admission, you must call our Authorized Administrator. This call should be made

as far in advance as possible but not less than 5-7 business days prior to the Hospital admission. — Included or deleted based on employer plan specifications.

Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits when you receive Inpatient Covered Services. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Inpatient Covered Services

- 1. Bed, Board and General Nursing Care when you are in:
 - a. a semi-private room
 - b. a private room (at semi-private room rate)
 - c. an intensive care unit
- 2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Payment of Inpatient Covered Expenses are subject to these conditions:

- 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.
- 3. No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery that you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

Parental Accommodation

Hospital charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12. Benefits are limited to a maximum of \$500 per inpatient admission. — *Included if selected by employer.*

Extension of Benefits in Case of Termination

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate that are rendered by and regularly charged for by a Hospital. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

Outpatient Hospital Care

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

- 1. Surgery and any related Diagnostic Service received on the same day as the Surgery
- 2. Radiation therapy treatments
- 3. MRI
- 4. Chemotherapy
- 5. Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
- Diagnostic Service when you are an Outpatient and these services are related to surgery or Medical Care
- 7. Emergency Accident Care treatment must occur within seventy-two (72) hours of the accident
- 8. Emergency Medical Care

Outpatient Hospital Care Benefit Payment

After you have met your Copayment, — Included if copayment applies. benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits.

Benefit Payment for Hospital Emergency Care

After you have met your Copayment, benefits will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits when you receive Emergency Accident Care or Emergency Medical Care.

If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

The Authorized Administrator must be notified within 48 hours of admission for emergency care. ← Included or deleted based on employer plan specifications.

Other Covered Services and Special Conditions

Ambulance Transportation

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.

Non Covered Services for Ambulance include but are not limited to, trips to:

- 1. a Physician's office or clinic;
- 2. a morgue or funeral home.
- 3. for long distance trips or for use of an ambulance because it is more convenient than other transportation

Autism Spectrum Disorders - Diagnosis and Treatment in Covered Children

Coverage is provided for the diagnosis and Treatment of Autism Spectrum Disorders and includes Applied Behavior Analysis supervised by a nationally board-certified behavior analyst and provided by a licensed Autism Services Provider for children beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

Benefits are payable on the same basis as any other sickness.

Ambulatory Surgical Facility

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Ambulatory Surgical Facility for Outpatient Surgery will be provided as shown in the Schedule of Benefits.

Services for Mental Illness

Both inpatient and outpatient coverage is provided for the diagnosis and treatment of Mental Illness. Benefits for Mental Illness services are the same as benefits for any other condition as specified in the Schedule of Benefits.

Cancer Clinical Trials

Benefits will be provided for routine costs for Covered Persons who participate in approved cancer clinical trials conducted under the auspices of the following cancer care providers:

- 1. Vermont Cancer Center at Fletcher Allen Health Care:
- 2. The Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center; and
- 3. any Hospital and its affiliated, qualified cancer care providers.

For participation in clinical trials located outside Vermont, coverage under this benefit will be provided only if the Covered Person provides notice to the health benefit plan prior to participation in the clinical trial, and:

- 1. no clinical trial is available at a Vermont or New Hampshire cancer care provider described above;
- the Covered Person has already completed a clinical trial at an approved cancer care provider listed above and that provider has determined that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available at that time under an approved cancer care provider listed above; or
- 3. a. The health plan has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available; and
 - b. the patient's cancer care provider determines participation in that clinical trial would be in the best interest of the Covered Person, even if a comparable clinical trial is available under an approved cancer care provider listed above.

If a Covered Person participates in a clinical trial administered by a cancer care provider that is not in the health benefit plan's provider network, the health plan may require that routine follow-up care be provided within the health benefit plan's network, unless the cancer care provider determines this would not be in the best interest of the Covered Person.

As used in this benefit, "health benefit plan" means the Policy any other applicable health benefit plan offered by the Insurer.

Cardiac Rehabilitation Services

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty.

Chiropractor Services

Exams, testing or manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractor Services as specified in the Schedule of Benefits.

Cleft Lip and Cleft Palate

Coverage shall be provided for Inpatient or Outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.

Dental Care for an Accidental Injury

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. No benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

Covered Services for accidental dental include, but are not limited to:

- 1. oral examinations:
- x-rays;
- 3. tests and laboratory examinations;
- 4. restorations;
- 5. prosthetic services;
- 6. oral surgery;
- 7. mandibular/maxillary reconstruction;
- 8. anesthesia.

Benefits are payable as stated in the Schedule of Benefits.

Durable medical equipment

Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose

Hormone Replacement Therapy

If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

Human Organ Transplants

Your benefits for certain human organ transplants will be limited to the amount as shown in the Schedule of Benefits. Benefits will be provided only for kidney, heart valve, heart, lung, heart/lung, or liver transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- 1. If both the donor and recipient have coverage with the Insurer, each will have their benefits paid by their own policy.
- 2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided only for you and not the donor.
- 3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided

- for you. However, no benefits will be provided for the recipient.
- 4. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

In addition to the above provisions, benefits for heart, lung, heart/lung or liver transplants will be provided as follows:

- 1. Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.
- 2. Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
- 3. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.
- 4. In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
 - a. Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery
 - b. Transportation by air ambulance for the donor or the recipient
 - c. Travel time and related expenses required by a Provider
 - d. Drugs that are Investigational
 - e. The cost of acquisition of the organ and any costs incurred by the donor

Infertility← Include the Infertility benefits if selected by policyholder.

Covered services related to the diagnosis of infertility shall be same as any other condition.

Covered Services related to the treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer will be provided as shown in the Schedule of Benefits.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments;
- 2. you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Special Limitations for Infertility Services

Benefits will not be provided for the following:

- 1. Services rendered to a surrogate mother for purposes of childbirth
- 2. Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures that use a cryo-preserved substance
- Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization or other such body as approved by the Authorized Administrator.

Infusion Therapy

Infusion Therapy is the administration of Drugs (Prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by feeding tube.

Covered Expense for Infusion Therapy (including all professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy) will not exceed the Average Wholesale Price as determined by the Insurer or the Negotiated Rate:

Covered Services for Infusion Therapy are as follows:

- 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.
- 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 <u>not</u> 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.

Medical Foods and Modified Food Products

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products when diagnosed and determined to be Medically Necessary by the Insured Person's Physician, and administered under the direction of a Physician.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry screened in newborn babies.

"Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means an amino acid modified preparation that is intended to be used under direction of a Physician for the dietary treatment of an inherited metabolic disease.

Ovarian Cancer Monitoring

Coverage shall be provided for CA-125 monitoring of ovarian cancer subsequent to treatment. This does not apply to routine screenings.

Other Covered Service

1. Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture

- 2. Allergy shots and allergy surveys
- 3. Blood and blood components
- 4. Leg, back, arm and neck braces
- 5. Oxygen and its administration
- 6. Medical and surgical dressings, supplies, casts and splints
- 7. Lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with guidelines set forth by the Division of Public Health
- 8. Scalp hair prosthesis Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease. Benefits are payable for up to \$500 per Policy *or* Calendar Year.

Pregnancy and Maternity Care

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Maternity benefits are **not** available for any Insured Person other than the Insured Participant or the Insured Participant's insured spouse or civil union partner or domestic partner — *Include if domestic partners covered*.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Private Duty Nursing Service

Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when our Authorized Administrator determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family

Prosthetic appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

- 1. they are required to replace all or part of an organ or tissue of the human body, or
- 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders and replacement of cataract lenses when a prescription change is not required).

Sterilization

The Insured Participant's Plan includes benefits for tubal ligation or vasectomy.

Treatment to Bones or Joints in the Face, Neck or Head

Benefits will be provided for the diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage will be:

- 1. the same as that provided under the Policy for any other musculoskeletal disorder in the body; and
- 2. provided when prescribed or administered by a Physician or a Dentist.

This benefit does not require coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

Home Health Care ← *Mandated offer; include Home Health Care if selected by the policyholder.*

Home Health services are limited each Policy Year as stated in the Schedule of Benefits for the following services. Services must be furnished by a Home Health Agency or a Visiting Nurses Association.

Benefits are provided when the Insured Participant or Insured Dependents are confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. A visit is defined as four or fewer hours of services provided by one of the following providers:

- 1. Services of a registered nurse.
- 2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- 3. If the Insured Person is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- 4. Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- 5. Services of a medical social worker.

All home health care services and supplies directly related to Infusion Therapy are included in the Infusion Therapy benefit and are not payable under this home health care benefit.

Hospice Services ← *Included Hospice Services if selected by the policyholder.*

Benefits for Hospice services are limited as stated in the Schedule of Benefits.

The Insured Person must be suffering from a terminal Illness for which the prognosis of life expectancy is 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.

Services and Supplies Provided by a Skilled Nursing Facility

Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

For any eligible condition that is Insurer Authorized, the Insurer will pay Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:

- 1. The Insured Person must be referred to the Skilled Nursing Facility by a Physician.
- 2. Services must be those, which are regularly provided and billed by a Skilled Nursing Facility.
- 3. The services must be consistent with the Insured Person's Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
- 4. The Insured Person must remain under the active medical supervision of a Physician treating the Illness or Injury for which he/she is confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- 1. Personal items, such as TV, radio, guest trays, etc.
- 2. Skilled Nursing Facility admissions in excess of 10 180 days per Policy *or* Calendar Year.

Hearing Services

Hearing Services include audiometric exams, hearing aid evaluation test, and limited benefits for hearing aids. See the Schedule of Benefits for maximums, which apply for Hearing Services. \(\bigsec\) Included this coverage if selected by the policyholder.

For Covered Persons who are Dependent Children under age 24, coverage provided for hearing aids up to the amount shown in the Schedule of Benefits.

Encluded this coverage if dependent children covered.

Vision Care ← *Included Vision Care coverage if selected by the policyholder.*

The Insurer will pay for Covered Expenses per Policy Year as stated in the Schedule of Benefits for routine Vision Care that is not the result of an Injury or Illness. The Deductible is not applicable.

Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and you must receive such care on or after your Coverage Date.

In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

- 1. Contact Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.
- 2. Frame means a standard eyeglass frame adequate to hold Lenses.
- 3. Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Covered Services

Benefits may be provided under this Benefit Section for the following:

- 1. Vision Examination
- 2. Single Vision Lenses
- 3. Bifocal Single Lenses
- 4. Bifocal Double Lenses
- 5. Trifocal Lenses
- 6. Lenticular Lenses
- 7. Contact Lenses
- 8. Frames

Special Limitations

Benefits will not be provided for the following:

- 1. Recreational sunglasses.
- 2. Medical or surgical treatment.
- 3. Drugs or any medication not administered for the purpose of a vision testing examination.
- 4. Orthoptics, vision training, subnormal vision aids, aniseikonic Lenses and tonoraphy.
- 5. Replacement of Lenses or Frames, which are lost or broken.

Benefit Payment for Vision Care

Benefits for Vision Care Covered Services will be provided for the services and at the payment levels listed in the Schedule of Benefits.

Dental Care ← *Included Dental Care coverage if selected by the policyholder.*

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Insurer until after receipt of a Dentist's or Physician's Claim form and/or the Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

The maximum amount available for you in dental benefits each Benefit Period is shown in the Schedule of Benefits. This is an individual maximum. This maximum applies to all of your Dental Covered Services, except for Orthodontic Dental Services where the maximum is the amount shown in the Schedule of Benefits.

Any expenses incurred beyond the benefit maximum are your responsibility.

Preventative Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for preventative treatment and necessary diagnostic examinations. Your Preventive Dental Services are as follows:

- 1. Oral Examinations The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every Benefit Period;
- Prophylaxis The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each Benefit Period;
- 3. Topical Fluoride Application Benefits for this application are only available to dependent children under age 19 and are limited to two applications each Benefit Period;
- Dental X-rays Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every twelve months;
- 5. Space Maintainers Benefits for space maintainers are only available to dependent children under age 19 and not when part of orthodontic treatment:
- 6. Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Primary Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Primary Dental Services. Covered Expenses include:

- Fillings
- 2. Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section

- 3. Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section
- 4. Endodontics
- 5. Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- 6. Apicoectomies
- 7. Hemisection
- 8. Biopsies of Oral Tissue
- 9. Periodontics/Periodontal Therapy; Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
- 10. Periodontal examination Benefits for periodontal examinations are limited to two per Benefit Period
- 11. Periodontal maintenance procedures Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
- 12. Stainless Steel Crowns
- 13. Repair of Removable Dentures
- 14. Recementing of Crowns, Inlays, Onlays and Bridges
- 15. General Anesthesia/Intravenous Sedation If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation
- 16. Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

Primary Dental Services are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.

Include this provision if elected by the policyholder.

Major Dental Services

The Insurer pays the percentage of Covered Expenses shown in the Schedule of Benefits for Major Dental Services. Covered Expenses Include:

- 1. Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- 2. Fixed Bridgework
- 3. Bridge Repairs
- 4. Full and Partial Dentures
- 5. Denture Adjustments, Rebasing and Relining During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture that could have been made serviceable.

Major Dental Services are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits.

Include this provision if elected by the policyholder.

Orthodontic Dental Care ← Include Orthodontic Dental Care if elected by the policyholder

Orthodontic Dental Care applies only if the Group has chosen Dental Care and Orthodontic Dental Care as shown in the Schedule of Benefits.

The Insurer pays the percentage of Covered Expenses indicated in the Schedule of Benefits for necessary orthodontic treatment subject to a specific lifetime maximum also shown in the Schedule. Once this lifetime limit is reached, the Insured Person has no right to any further orthodontic treatment benefits.

Up to the age of 18, \[Construction Included or deleted. Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. The limitations are as follows:

- 1. Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist;
- 2. Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
- 3. Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment

After your orthodontic treatment has been completed, no further orthodontic benefits will be provided until 5 years have elapsed.

Orthodontic expenses are not covered during the initial period the Insured Person is insured as stated in the Schedule of Benefits. Include this provision if selected by the policyholder.

Special Limitations

No benefits will be provided under this Benefit Section for:

- 1. Dental services which are performed for cosmetic purposes.
- 2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
- 3. Oral Surgery for the following procedures:
 - a. surgical services related to a congenital malformation;
 - b. surgical removal of complete bony impacted teeth;
 - c. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
- 4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
- 5. Hospital and ancillary charges are not covered.
- Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.
- 7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

Accidental Death and Dismemberment Benefit ← Include AD&D Benefit if selected by the policyholder.

The Insurer will pay the benefit stated below if an Insured Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss Benefit

Loss of life100% of the Principal SumLoss of one hand50% of the Principal SumLoss of one foot50% of the Principal SumLoss of sight in one eye50% 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. — Included if selected by the policyholder.

Catastrophic Limitation. Except as may otherwise be provided, the total liability hereunder for deaths and Injuries suffered by any number of Insured Persons in any one Accident or disaster shall not exceed the sum of \$300,000 - \$500,000. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed \$300,000 - \$500,000 the amount of indemnity payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed \$300,000 - \$500,000. In the event of any such Accident or disaster for which all indemnities payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed \$300,000 - \$500,000. In the event of any such Accident or disaster for which all indemnities payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed \$300,000 - \$500,000.

Repatriation of Remains Benefit Include Repatriation Benefit if selected by the policyholder.

If an Insured Person dies, while traveling outside of his/her home country, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

No benefit is payable if the death occurs after the Termination Date of the Policy. However, if the Insured Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Insured Person's Confinement ends or 31 days after the Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

The benefit for all necessary repatriation services is listed in the Overview Matrix.

Medical Evacuation Benefit ← Include Medical Evacuation Benefit if selected by the policyholder.

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 Overview Matrix, 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.

If you have minor children who are left unattended as a result of your injury, illness or medical evacuation, our Authorized Administrator will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to your Home Country or Country of Assignment.

The combined benefit for all necessary evacuation services is listed in the Overview Matrix.

Bedside Visit Benefit ← Include Bedside Visit Benefit if selected by the policyholder.

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than 3 – 7 days, is likely to be hospitalized for more than 3 – 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 3 – 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

1. The following services and supplies are not covered:

Hospitalization, services and supplies that are not Medically Necessary.

No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately
 in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by Authorized Administrator after you have been hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Insurer will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Insurer, either at law or in equity. To initiate your appeal, you must give Insurer written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

Remember, even if your Physician prescribes, orders, recommends, approves or views hospitalization or other health care services and supplies as Medically Necessary, the Insurer will not pay for the hospitalization, services and supplies if its authorized administrator decides they were not Medically Necessary

2. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are provided under any Workers' Compensation Law or other similar laws. This exclusion does not apply to Protection and Indemnity Insurance for Marine crew

members. ← Included or deleted by agreement between the company and the policyholder

- 3. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided by a local, state or federal government (except Medicaid).
- 4. Services and supplies for any illness or injury occurring on or after your Coverage date as a result of participation in war, riot, civil commotion or any illegal act.
- Custodial Care Service.
- 6. Routine physical examinations, unless otherwise specified in this Certificate.
- 7. Cosmetic Surgery and related services and supplies, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease or the involved part, and reconstructive surgery because of a congenital diseases or anomaly of a covered dependent child which has resulted in a functional defect.
- 8. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- 9. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- 10. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
- 11. Foot care, except for persons diagnosed with diabetes, in connection with corns, calluses, flat fee, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

 *- Included or deleted by agreement between the policyholder and the company.
- 12. Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.

 Included or deleted by agreement between the policyholder and the company.
- 13. Services and supplies to the extent benefits are duplicated because the spouse or civil union partner or domestic partner \(\bigcup \) Include if domestic partners covered, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- 14. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- 15. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- 16. Consultations performed by you, your spouse, civil union partner or domestic partner, parents or children.
- 17. Treatment for hair loss. ← Included or deleted by agreement between the policyholder and the company.
- 18. Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK). *Included or deleted by agreement between the policyholder and the company.*
- 19. Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate. Included or deleted by agreement between the policyholder and the company.
- 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.

 Included or deleted by agreement between the policyholder and the company.
- 21. Contact lenses and glasses unless otherwise specified in this Certificate.

 Included or deleted by agreement between the policyholder and the company.
- 22. Services and treatment related to elective abortions.

 Included or deleted by agreement between the policyholder and the company.
- 23. Sterilization or the reversal of sterilization, unless otherwise specified in this Certificate. Included or deleted by agreement between the policyholder and the company.
- 24. Elective Abortions. ← Included or deleted by agreement between the policyholder and the company.
- 25. Dental services unless elected by your Group.

 Included or deleted by agreement between the policyholder and the company.
- 26. Vision care services unless elected by your Group. ← Included or deleted by agreement between the policyholder and the company.
- 27. Loss arising from ultra light aircraft *and/or* parasailing *and/or* sail planning *and/or* hang gliding.
- ↑ Numbering may change depending upon exclusions shown.

Pre-existing Conditions

Benefits are not available for any services received on or within 6 months after the Eligibility Date of an Insured Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to pregnancy, congenital anomalies of a covered dependent, a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, or Insured Dependents under age 19.

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. — Included or deleted based on plan specifications.

VII. Prescription Drug Benefits ← Prescription Drug Benefits included if elected by the policyholder.

Introduction and Definitions

To understand the Insured Person's Prescription Drug Benefits, it may be helpful to review these important terms:

Average Wholesale Price (AWP) is the average wholesale price of a Drug as determined by the Insurer.

Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented and is only produced by one manufacturer.

Drugs (Prescription Drugs) mean Prescription Drugs approved by state law or the Federal Food and Drug Administration for general use by the public. (See section on Conditions of Service for exceptions.) For purposes of this benefit, insulin is considered a Prescription Drug.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Maintenance Prescription Drugs are Prescription Drugs that are taken for an extended period of time to treat a medical condition.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with the Insurer at the time services are rendered. Call the Insured Person's local Pharmacy or call the toll-free Prescription Benefit Customer Service phone number x-xxx-xxxx-xxxx ← Actual phone number will be shown. for a list of Participating Pharmacies in the Insured Person's area.

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

- 1. Outpatient Drugs and medications that federal and/or State law restrict to sale by Prescription only.
- Insulin.
- 3. Insulin syringes prescribed and dispensed for use with insulin.
- 4. All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.

Prescription drugs purchased in Canada, and used in Canada or re-imported legally or purchased through the I-SaveRx program, will be covered on the same benefit terms and conditions as prescription drugs purchased in the U.S.

Conditions of Service

The Drug or medicine must be:

- 1. Prescribed in writing by a Physician and dispensed within one Calendar Year of being prescribed, subject to federal or state laws.
- 2. Approved for use by the Food and Drug Administration.
- 3. For the direct care and treatment of the Insured Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included.
- 4. Purchased from a licensed retail Pharmacy.

The drug or medicine must **not** be used while the Insured Person is an inpatient in any facility.

The Prescription must not exceed a 30 – 180 -day supply.

Reimbursement

Many Prescription Drugs are available in Generic form, which is more cost effective for the Insured Person. It may be to the Eligible Participant's advantage to ask the Insured Person's Physician to prescribe and the Insured Person's pharmacist to dispense Generic Drugs whenever possible.

The amount reimbursed by the Insurer for claims for Prescription Drugs is separate from and will not be applied toward any coinsurance amount described in the Covered Services section of this Plan.

When the Insured Person Goes to a Participating Pharmacy

When the Insured Person or an Insured Dependent has a Prescription filled, the Insured Person's identification card should be presented and the Insured Person should identify himself/herself as an Insured Person of the Insurer. The Pharmacy will calculate the Insured Person's remaining deductible and Copayment. The Insured Person will not need to submit claim forms but is responsible for paying Deductible and Co-insurance amounts to the Pharmacy. The Insured Person will have the following Copayment for each covered Prescription and/or refill after his/her Deductible is satisfied:

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits.
- 3. For injectable, the Insured Person pays as stated in the Schedule of Benefits.

For information on how to locate a Participating Pharmacy in the Insured Person's area, call x-xxx-xxxx-xxxx.

Actual phone number will be shown.

When the Insured Person Goes to a Non-Participating Pharmacy

If the Insured Person purchases a Prescription Drug from a Non-Participating Pharmacy, he/she will be responsible for the amount stated in the Schedule of Benefits as well as any charge, which exceeds the Reasonable Charge of the Drug. He/she will need to have the pharmacist complete his or her portion of the Prescription Drug Claim Form. The Insured Person will pay the pharmacist for the Prescription, complete the Insured Person's portion of the Prescription Claim Form and then submit the Eligible Participant's claim to the Insurer for reimbursement within 15 months of the date of purchase. If the Insured Person has not satisfied his/her Deductible at the time his/her claim is submitted, the amount the Insured Person paid for the Prescription may be applied toward his/her Deductible amount. The Insured Person's Prescription is considered purchased on the date he/she receives the Drug for which the charge is made. The completed claim form should be submitted to the address included on the Prescription Claim Form.

When the Insured Person has his/her Prescription filled at a Non-Participating Pharmacy he/she will be reimbursed at the following rate for each covered Prescription and/or refill after the Insured Person's deductible is satisfied:

- 1. For Generic Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits plus any amount over Reasonable Charges.
- 2. For Brand Name Prescription Drugs, the Insured Person pays as stated in the Schedule of Benefits, plus any amount over Reasonable Charges.

Claims and Customer Service

Drug claim forms are available at Participating Pharmacies or upon written request to Insurer.

If the Insured Person has any questions about his Prescription Drug Benefit, call the toll-free customer service number: **x-xxx-xxxx &** *Actual phone number will be shown.*

Prescription Drug Exclusions and Limitations bracketed exclusions included or removed and renumbered

Prescription Drug reimbursement is subject to and treated as part of any benefit maximums, limitations on Pre-existing Conditions or any other exclusions or limitations contained in this entire Plan. In addition, reimbursement will not be provided for:

- 1. Drugs and medications not requiring a Prescription, except insulin.
- 2. Self-administered injectable drugs, except insulin.
- 3. Non-medical substances or items.
- 4. Contraceptive Drugs and/or certain devices prescribed for birth control, ← Included if mandated unless employer objects due to religious reasons.

 Drugs and medications used to induce non-spontaneous abortions. ← Included if mandated unless employer objects due to religious reasons; if not mandated, included or deleted by agreement between the policyholder and the company.
- 5. Dietary supplements, cosmetics, health or beauty aids.
- 6. Any vitamin, mineral, herb or botanical product, which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
- 7. Drugs taken while the Eligible Participant are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
- 8. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
- 9. Syringes and/or needles, except those dispensed for use with insulin.
- 10. Durable medical equipment, devices, appliances and supplies.
- 11. Immunizing agents, biological sera, blood, blood products or blood plasma.
- 12. Oxygen.
- 13. Professional charges in connection with administering, injecting or dispensing of Drugs.
- 14. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
- 15. Drugs used for cosmetic purposes.
- 16. Drugs used for the primary purpose of treating infertility. ← Deleted if infertility covered.
- 17. Anorexiants or Drugs associated with weight loss.
- 18. Drugs obtained outside the United States. ← Included or deleted by agreement between the policyholder and the company.
- 19. Allergy desensitization products, allergy serum.
- 20. All Infusion Therapy is excluded under this Plan except as specifically stated in the Covered Services section.
- 21. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Preexisting Condition, or other contract limitation.
- 22. Growth Hormone Treatment.
- 23. Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
- 24. The replacement of lost or stolen Prescription Drugs. — Included or deleted by agreement between the policyholder and the company.
- 25. Antihistamines. ← Included if selected by the policyholder.
- ↑ Numbering may change depending upon exclusions shown.

VIII. General Provisions

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 Policy Year, and are largely determined by 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 <u>Definitions</u> 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;
- 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.

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 has been received, the Insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the Insured Person the reasons the Insurer may have for denying such claim or any portion thereof.

Subject to proof of loss, all accrued benefits payable under the Plan for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the Insurer are liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Time Payment of Claims: Benefits for a loss covered under this Plan will be paid as soon as the Insurer receive proper written proof of such loss. Any benefits payable to the Eligible Participant and unpaid at the Eligible Participant's death will be paid to the Insured Person's estate.

Payment of Claims: The Insurer may pay all or a portion of any indemnities provided for health care services to the participating health care services provider, unless the Insured Participant directs otherwise in writing by the time proofs of loss are filed. The Insurer will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services provider directly to the Insured Person, unless the Insured Participant directs otherwise in writing by the time proofs of loss are filed. The Insurer cannot require that the services be rendered by a particular health care services provider.

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:

- 1. It is duly executed on a form acceptable to the Insurer; and
- 2. A copy is on file with the Insurer.

The Insurer assumes no responsibility for the validity or effect of an assignment.

Payment for services provided by a Participating Provider is automatically assigned to the provider. The Participating Provider is responsible for filing the claim and the Insurer will make payments to the provider for any benefits payable under this Plan. Payment for services provided by a Non-Participating Provider are payable to the Insured Participant unless assignment is made as above.

Payment to a Managing Conservator: Benefits paid on behalf of a covered dependent child may be paid to a person who is not the Insured Participant, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the child.

To be entitled to receive benefits, a managing conservator of a child must submit to the Insurer with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured Participant where the Insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

Misstatement of Age: If the age of an Insured Person has been misstated, an adjustment of premiums shall be made based on the Insured Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

Right to Recovery: If the Insurer makes benefit payments in excess of the benefits payable under the provisions of the Plan, the Insurer has the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.

Plan Administrator. In no event will the Insurer be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than the Insurer, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Eligible Participant's agent.

Waiver of Rights: Failure by the Insurer to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

Physical Exam and Autopsy: The Insurer has the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Insured Participant will not have to pay for it.

Required Information: The Group will furnish the Insurer all information necessary to calculate the Premium and all other information that the Insurer may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. The Insurer has the right to examine any records of the Group, any person, company or organization which may affect the Premiums and benefits of the Plan.

The Insurer's right to examine any records that exist:

- 1. During the time the Plan is in force; or
- 2. Until the Insurer pay the last claim.

The Insurer is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities are providers act as independent contractors and not as employees, agents or representatives of the Insurer.

The Insurer will provide written notice to the Insured Participant within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if the Insurer determines that the Insured Participant or his/her Insured Dependents may be materially and adversely affected, and provide the Insured Participant with a current list of Participating Providers.

The Insurer will provide the Group with an updated list of local Participating Providers annually. If the Insured Participant needs a new provider listing for any other reason, he/she may call the Insurer at, and the Insurer will provide the Insured Participant with one.

The Insurer is entitled to receive from any provider of service information about the Insured Person which is necessary to administer claims on the Insured Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Insured Participant has authorized every provider furnishing care to disclose all facts pertaining to the Insured Participant's and his/her Insured Dependent's care, treatment, and physical condition, upon the Insurer's request. The Insured Participant agrees to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services.

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS.

Grievance Procedures: If the Insured Person's claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

Review and determination of mental health claims may only be made by a licensed Mental Health Review Agent with the concurrence of a Mental Health Care Professional whose training and expertise is at least comparable to that of the treating clinician.

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:

4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181 (800) 621-9215

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.

Appeal Process

Expedited Claim Appeal

When an appeal concerns (a) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (b) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, you may request your appeal to be expedited.

Upon submission of an expedited appeal, you will be notified as soon as possible, but no later than 72 hours after the appeal is filed and the review agent receives all information necessary to complete the appeal.

First Level Appeal

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied, you may appeal your Claim. You may submit any additional information and comments on your Claim and you must request an appeal no later than 60 days after the denial by writing to:

Authorized Administrator — *Actual name of authorized administrator will be shown.*

Address Actual address of authorized administrator will be shown.

City, State, zip code ← Actual address of authorized administrator will be shown.

Telephone number: ← Actual phone number will be shown.

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. If we require additional information, we will advise you within the first three days of your request.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Second Level Appeal

If your first level appeal is unsuccessful, and you want your appeal to be reviewed, you may request a second level appeal. You must request a second level appeal no later than 60 days after the first level appeal by writing to:

Authorized Administrator \leftarrow *Actual name of authorized administrator will be shown.*

Address ← Actual address of authorized administrator will be shown.

City, State, zip code ← Actual address of authorized administrator will be shown.

Telephone number: ← Actual phone number will be shown.

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. You may add information to the file by submitting it in writing.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Independent External Review

When a Covered Person has exhausted all applicable internal review procedures provided by the Insurer, such Covered Person will have the right to an independent external review of any decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review will be available when requested in writing by the affected insured, provided the decision to be reviewed requires the Insurer to expend at least \$100.00 for the service and the decision by the plan is based on one of the following reasons:

- 1. The health care service is a covered benefit that the health insurer has determined to be not medically necessary.
- 2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and rules.
- 3. The health care treatment has been determined to be experimental, investigational or an off-label drug. A health benefit plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal, and shall decide such appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the commissioner.
- 4. The health care service involves a medically-based decision that a condition is preexisting.

The right to an independent review will not be construed to change the terms of coverage under the Policy.

The independent external reviews will be conducted:

- 1. By independent review organizations pursuant to a contract with the department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section; and
- 2. In accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

The Covered Person will:

- 1. be provided with adequate notice of their review rights under this section;
- 2. have the right to use outside assistance during the review process and to submit evidence relating to the health care service;
- 3. pay an application fee of \$25.00 for each request for an independent external review of an appealable decision not to exceed a total of \$75.00 annually. The application fee may be waived or reduced based on a determination by the Commissioner of Insurance that the financial circumstances of the Covered Person warrants a waiver or reduction. The application fee will be paid by the Insurer, not the Covered Person, if the independent review organization reverses the Insurer's decision to deny payment for a health care service; and
- 4. Be protected from retaliation for exercising their right to an independent external review.

Other costs of the independent review will be paid by the Insurer.

The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan.

The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable state or federal laws.

The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure in accordance with Vermont law.

Decisions relating to the following health care services shall not be reviewed under this section, but shall be reviewed by the review process provided by law:

- 1. Health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan.
- 2. Health care services provided to inmates by the Department of Corrections.

SERFF Tracking #: BCSF-130097000

Company Tracking #: 54.1201 VT (EX-PAT RATES)

Dear Mr. Crompton:

This is in response to your objection letter of 6/11/15. Responses are given below each numbered objection.

1. The "Rate Review Detail" shows \$0.00 annualized PMPM for the minimum, maximum, and weighted average categories. Even though this is an initial rate filing for this product, there must be rate/premium values filled in for these categories.

Along with these responses we have updated the Rate Review Detail to include non-zero figures. Since there is only one product, the minimum, maximum, and average values are the same. Revised Rate Review Detail is submitted under post submission update.

2. Regarding retention, the second table item 8 in the actuarial memorandum, indicates group sizes of 50, 2-399, and 400+. The corresponding table in the rate manual (page 3, section "XV. Retention,") shows group sizes of 1, 2-499, and 400+. Why is there a difference between the two tables? Also, why is there an overlapping group size in the table on page 3 of the rate manual (i.e. "2-499", and "400+")?

We have fixed the actuarial memorandum and rate manual so that the two tables match and have fixed the overlap issue.

3. Regarding retention on the second table item 8 in the actuarial memorandum, what does the unlabeled 27.0% represent?

We have now labeled that row to indicate that it is the expected weighted average of the Retention amounts (using the distribution by case size in the third column).

4. Regarding "Expenses and Commissions" on the first table item 8 in the actuarial memorandum, the administration charge of 18.5% is high. Provide the calculations (with a breakdown of all component parts) and an explanation of the administration charge. Also, regarding the first submission of this rate filing on 03/04/2015 (which was rejected), the administration charge was shown as 23.5% in item 8 of the actuarial memorandum. Given that this is the same product (Forms 54.1201), explain the difference in the two rate filings between an administration charge of 23.5% and 18.5%.

The Administration charge breaks down as 13.5% for the TPA fee and 5.0% for BCS's general overhead expenses. Regarding changes in this charge from the earlier filing, BCS was able to secure lower pricing on its TPA arrangement.

Regarding your comment that the 18.5% charge is high, please keep in mind that there are expenses involved in administering expatriate plans that do not exist in typical major medical plans.

The unique cost characteristics of plans covering expatriate employees and their dependents were identified in 2011 by the United State Department of Health and Human Services (HHS) and Centers of Medicare and Medicaid Services (CMS) noting "that these policies have higher administrative costs as a result of (1) Providing international access to providers; (2) maintaining emergency evacuation services; and (3) navigating health care and legal systems in different countries. These policies may also have unpredictable experience depending on the location of the enrollees. One issuer stated that a large portion of international policies are sold through brokers, and high broker fees contribute to the increased administrative cost. We received no comments opposing a special circumstances adjustment for expatriate policies." (FEDERAL REGISTER VOLUME 76, NUMBER 235 DECEMBER 7, 2011). These concerns prompted HHS to determine that for MLR reporting requirements for Expatriate plans that a factor of 2 times the effective claims costs could be used as the numerator in MLR determinations (Interim Final Rule on 12/1/2010 concerning MLR and Final Rule 12/7/2011). The Expatriate Health Coverage Clarification Act of 2014 exempting expatriate plans from key provisions of the Affordable Care Act such as MLR reporting further confirmed the unique status of expatriate plans. In addition to the factors noted above by HHS, costs of administering expatriate plans are impacted by low volumes of claims submitted electronically and high volumes of claims that are submitted in languages other than English and that do not conform to US coding standards thereby adding substantial additional cost to insurers. Other costs include providing translation and other services to enrollees, helping subscribers locate qualified providers in different countries, 24-hour call centers, and identifying and credentialing providers worldwide in countries with different licensing and other requirements from those found in the United States.

5. Regarding "Expenses and Commissions" on the first table item 8 in the actuarial memorandum, the average commissions of 8.0% is high. Provide the calculations (with a breakdown of all component parts) and an explanation of the average commission charge. Also, since this is an average commission charge, what are the ranges for these charges? Provide an explanation of why there would be different commission charges for this product.

The range is 0-15%, shown in the actuarial memorandum, Item 8, beneath the first table. The commission rate will vary by broker and case size, with the rate averaging around 4% for the larger groups

6. Regarding "Premium Taxes" of 2.5% on the first table item 8 in the actuarial memorandum, does this include a retaliatory tax?

The rate of 2.5% represented a nationwide average. The premium tax for this filing has been changed to 2.0%

7. Regarding "Contingency and Risk Margin" on the first table item 8 and item 22 in the actuarial memorandum, the contingency and risk margin of 6.0% is high. Provide the calculations (with a breakdown of all component parts) and an explanation for this margin.

The contingency and risk margin is set to accommodate increased risks in the expatriate plans that aren't typical in domestic plans. For example, the risk involved in currency fluctuations, and large differences in costs in some countries between rural and urban providers that increase the variability of total claim costs and the risks of changing regulations in multiple countries.

8. Regarding item 13 "Area Factors" in the actuarial memorandum, it states "rates will vary by zip code and nationality as shown in the rate manual." The rate manual shows, on page 7, area factors by country, but there appears to be no reference to zip code. Explain.

The area factors by zip code have been added to the rate manual.

9. Regarding item 20 (Minimum Required Loss Ratio) and item 24 (Anticipated Loss Ratio), the current actuarial memorandum shows 65.0%. The first submission of this rate filing on 03/04/2015 (which was rejected), showed an MLR and Anticipated Loss Ratio of 60.0% in the actuarial memorandum. Given that this is the same product (Forms 54.1201), explain the difference in the loss ratios of 65% and 60% between the two filings.

Please see objection #4 response, above, regarding the reduction in TPA fees. This had the corresponding impact of raising the anticipated loss ratio to 65%, now 65.5% after adjusting the premium tax.

10. Provide a signed and dated confirmation by a qualified company actuary that this rate filing is in full compliance with the "Expatriate Health Coverage Clarification Act of 2014."

This confirmation has been added to Item 27 of the actuarial memorandum.

Randall Jones, FSA, MAAA Sierra Actuarial Services, Inc. 6/18/2015 SERFF Tracking #: BCSF-130097000 State Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| | Schedule Item | | | Replacement | |
|---------------|---------------|---------------------|---|----------------------|--|
| Creation Date | Status | Schedule | Schedule Item Name | Creation Date | Attached Document(s) |
| 06/03/2015 | | Supporting Document | EXCEL COPY - RATE MANUAL | 06/18/2015 | VT Expat Rate Manual 2015_05_20.xlsx (Superceded) |
| 05/27/2015 | | Rate | Rate Manual | 06/18/2015 | VT Expat Rate Manual 2015_05_20.pdf (Superceded) |
| 05/27/2015 | | Supporting Document | Actuarial Memorandum and Certifications | 06/18/2015 | VT_4EL_ExPat_Act_Memo_revised _20150518.pdf (Superceded) |

SERFF Tracking #: BCSF-130097000 State Tracking #: 54.1201 VT (EX-PAT RATES)

State: VermontGMCB Filing Company: 4 Ever Life Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002C Large Group Only - Other

Product Name: Group Major Medical - Ex-Pat (Rates)

Project Name/Number: Group Major Medical - Ex Pat (Rates)/54.1201 VT (Ex-Pat Rates)

Attachment VT Expat Rate Manual 2015_05_20.xlsx is not a PDF document and cannot be reproduced here.

4Ever Life Insurance Company Global HealthGuard Rate Manual Effective 7/1/2015 Table of Contents

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| V. Relative Geographical Cost (See Table C) | 2 |
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I. Benefit Plan Base Rates (See Table A)

All plans are compared to the base rate shown in Table AA Claims Premium.

The Medical Base Rate is \$337.00 The Rx Base Rate is \$104.00

The ADD Base Rate is \$0.045 per thousand

II. Usage (split In US in-network, In US out-of-network, Overseas, totals 1.000)

U.S. Citizen Overseas usage: .70

U.S. In-network usage: 5/6 times (1-overseas usage)
U.S. Out-of-network usage: 1/6 times (1-overseas usage)
Overseas usage if an alien traveling aborad: .10

III. Premium Cost:

Base Rate minus A, minus B and coinsurance times C where:

A-Deductible covered claims cost = Deductible divided by .5 if overseas

I using deductible covered claims interpolated for interim values

B-Maximum covered claims Cost = [Deductible+minimum(maximum benefit+out-of-pocket; maximum benefit/coinsurance)]/.5 if overseas

I using maximum covered claims interpolated for interim values

C-Out-of-pocket covered claims cost = out-of-pocket/(1-coinsurance) (after the deductible covered claims) divided by .5 if overseas

Premium calculated using out-of-pocket covered claims interpolated for interim values

IV. Plan Design Factor - See Table B

Equals Premium Cost divided by standard benefit plan premium.

Base Plan Medical = US, 80% coinsurance, \$0 deductible, \$2k out-of-pocket, \$5m maximum.

Base Plan Rx = Unlimited maximum, no copays or coinsurance

V. Relative Geographical Cost - See Table C

U.S. In-network: .90 for medical, 1.00 for Rx U.S. Out-of-network: 1.25 for medical, 1.00 for Rx

Overseas: .35 times area factor for medical (weighted average by enrollment), .65 for Rx

VI. Office Visit Copay Factor

Expected number of office visits times cost of an office visit times coinsurance

 $\label{eq:minus} \mbox{minus expected number of office visits times cost of an office visit less the office visit copay}$

all divided by the base rate

VII. Hospital Out-of-Network Copay Factor

The factor is .97 if there is a hospital out-of-network copay

VIII. Medical Evacuation Factor - Table D

From the table shown below; interim values interpolated

IX. Integrated Deductible Factor (Medical and Rx)

For high deductibles, the Rx cost is reduced by 35%.

For deductibles below \$250, it is reduced by 35% times deductible/250

X. Trend Factors

Monthly Factor = 1 + annual factor/12 ** months from manual date to effective date

 Benefit
 Annual Factor

 Medical Rx
 10.3%

 Dental
 6.0%

 Vision
 4.0%

XI. Anti-Selection Factor (interpolated for interim values)

| Plan Design Factor | Factor |
|--------------------|--------|
| 0.4 | -0.12 |
| 0.5 | -0.09 |
| 0.6 | -0.06 |
| 0.7 | -0.03 |
| 0.8 | 0.00 |
| 0.9 | 0.03 |

XII. Maximum Benefit Factor (interpolated for interim values)

| Maximum Benefit | Factor |
|-----------------|--------|
| 0 | 0.00 |
| 1,100,000 | 0.03 |
| 6,000,000 | 0.05 |
| 999,999,999 | 0.07 |

XIII. Group Size Factor (interpolated for interim values)

| Group Size Factor | Factor |
|-------------------|--------|
| 1 | 0.425 |
| 2 | 0.350 |
| 3 | 0.275 |
| 4 | 0.200 |
| 5 | 0.125 |
| 6 | 0.050 |
| 7+ | 0.000 |

XIV. Age Gender Factors (weighted average by enrollment)

| Age | Male | Female | Dep. Child |
|-------------|-------|--------|------------|
| 0-24 | 0.33 | 0.75 | 0.367 |
| 25-29 | 0.41 | 0.98 | 0.367 |
| 30-34 | 0.52 | 1.14 | 0.367 |
| 35-39 | 0.67 | 1.14 | 0.367 |
| 40-44 | 0.83 | 1.17 | 0.367 |
| 45-49 | 1.06 | 1.38 | 0.367 |
| 50-54 | 1.45 | 1.67 | 0.367 |
| 55-59 | 1.89 | 1.97 | 0.367 |
| 60-64 | 2.56 | 2.34 | 0.367 |
| 65-69 | 3.45 | 2.78 | 0.367 |
| 70-74 | 4.91 | 3.96 | 0.367 |
| 75-79 | 6.12 | 4.94 | 0.367 |
| 80-84 | 7.31 | 5.9 | 0.367 |
| 85-89 | 8.87 | 7.16 | 0.367 |
| 90-94 | 11.32 | 9.13 | 0.367 |
| 95 or above | 12.4 | 10.01 | 0.367 |
| | | | |

XV. Retention

| Group Size | Retention Before Commission |
|------------|-----------------------------|
| 1 | 0.385 |
| 2-499 | 0.365 |
| 400+ | 0.245 |

XVI. Dental and Vision

Only one dental plan and one vision plan is to be sold. The rates do not vary by age, area, group size, retention, commission, etc. $\frac{1}{2}$

The Premium rates for an Employee, Spouse and Child are as follows:

| Relation | Dental | Vision |
|----------|---------|---------|
| EE | \$43.00 | \$14.00 |
| Spouse | \$49.00 | \$14.00 |
| Child | \$12.90 | \$4.20 |

XVII. Tier Factors

Since rates are calculated for Employee (or Participant), Spouse and Child, the tier rates are derived.

The number of expected spouses per employee and children per employee at each tier is as follows:

| | | #Sp in Tier | #Chrn in Tier |
|------------|----------------|-------------|---------------|
| Two Tier | Comp Dep | 0.9 | 1.8 |
| Three Tier | One Dep | 0.9 | 0.1 |
| Three Tier | 2+ Deps | 0.9 | 2.5 |
| Four Tier | Spouse | 1 | 0 |
| Four Tier | Child/Children | 0 | 2 |
| Four Tier | Family | 1 | 3.1 |

XVIII. Experience Rating (See Table E)

For larger groups, an experience rate is used for Medical and Rx when actual credible claims is obtainable.

A blend of the manual rate and an experience rate will be used weighted by a credibility factor (CF) (See Table E).

Actual claims is adjusted from the midpoint of the experience period to the midpoint of the rating period.

If claims are on a paid basis (rather than an incurred basis), lagged actual claims may be used.

If sufficient data is available, incurred claims will be calculated using a claims triangle reserve method.

Actual claims may also be adjusted if benefits or network availability will be changed.

The basic formula is as follows:

Final Rate = Experience Rate times CF plus Manual Rate times (1-CF)

Sample Rate Calculation

Policy Effective 1/1/2015

| 1 Medical Benefit | US-IN | US-OUT | Oversea | Rx | | | | | |
|--|----------------|----------------|-----------------|-------------------|---------------|------------------|---------------|---------|----------------|
| 2 Location | US | US | Oversea | All | | | | | |
| 3 Coinsurance | 80% | 60% | 90% | 100% | | | | | |
| 4 Deductible | \$0 | \$1,000 | \$50 | \$0 | | | | | |
| 5 Out-of-Pocket | \$2,000 | \$2,000 | \$2,000 | No Copays | | | | | |
| 6 Maximum | \$5m | \$5m | \$5m | Unlimited | | | | | |
| 7 Rx-Integrated-Deduc? | N | N | N | | | | | | |
| 8 OfficeVisitCopay, i.e. 10 | \$30 NA | N N | N NA | | | | | | |
| 9 Hospital Out-of-Network 10 AD&D | NA N | N N | NA N | | | | | | |
| 11 Medical Evacuation | \$100,000 | \$100,000 | \$100,000 | | | | | | |
| | ψ.00,000 | | ψ.00,000 | | | | | | |
| 12 Medical Base Rate | \$337.00 | \$337.00 | \$337.00 | | | | | | |
| 13 Usage Percent | 0.25 | 0.05 | 0.70 | | | | | | |
| 14 Plan Design Factor | 1.000 | 0.826 | 1.006 | | | | | | |
| 15 Relative Geographical Cost | 0.900 | 1.250 | 0.350 | | | | | | |
| 16 Office Visit Copay 17 Hospital Out-of-Network | 0.997 1.000 | 1.000 1.000 | 1.000 1.000 | | | | | | |
| 18 Medical Evaculation Adj | 1.000 | 1.000 | 1.000 | | | | | | |
| 19 Untrended Medical Plan | \$75.60 | \$17.40 | \$83.06 | \$176.06 | | | | | |
| | | | | • | | | | | |
| 20 Rx Base Rate | \$100.40 | \$100.40 | \$100.40 | | | | | | |
| 21 Usage Percent | 0.25 | 0.05 | 0.70 | | | | | | |
| 22 Plan Design Factor | 1.000 | 1.000 | 1.000 | | | | | | |
| 23 Coinsurance | 100% | 100% | 100% | | | | | | |
| 24 Integrated Deductible Factor | 1.000 | 1.000 | 1.000 | | | | | | |
| 25 Relative Geographical Cost | 1.000 | 1.000 | 0.650 | | | | | | |
| 26 Untrended Rx Plan Cost | 25.10 | 5.02 | 45.68 | \$75.80 | | | | | |
| 27 Untrended Medical & Rx (19+26) | | | | \$251.86 | | | | | |
| 28 Trend: Medical/Rx; Den | 1.009 | 1.005 | 1.003 | | | | | | |
| 29 Anti-Selection Factor | 0.030 | | | | | | | | |
| 30 Maximum Benefit Factor | 0.030 | | | | | | | | |
| 31 Group Size Factor | 0.000 | | | | | | | | |
| 32 Combined Factors (28*(| 1.069 | | | \$269.26 | | | | | |
| 33 AD&D | 0.000 | 0.000 | NA | | | | | | |
| 34 Age Factors (Partic, Sp, Children) | 1.000 | 1.000 | 0.367 | | | | | | |
| 35 Med&Rx Before Retention | 269.26 | 269.26 | 98.82 | | | | | | |
| 36 Med,Rx,ADD Before Retention | 269.26 | 269.26 | 98.82 | | | | | | |
| 37 Retention(R) & Commission(C) | 0.245 | 0.050 | | | | | | | |
| 38 Rates After Retention (P | 375.41 | 375.41 | 137.77 | | | | | | |
| 39 Med,Rx Per Employee | 269.26 | | | | | | | | |
| 2 Tier | | | | | TOTAL | A #Sp in Tier | A BB #Chrn | in tier | |
| 2 1161 | #Units | ED-Rx-AD& | DENTAL | VISION | TOTAL | #Op III Tiel | #CIIII | iii uci | |
| 40 Participant (38ee) | 438 | \$375.41 | \$43.22 | \$14.05 | | | | | |
| 41 Participant & Family | 0 | \$961.27 | \$110.87 | \$34.27 | | 0. | 9 1.8 | | |
| 42 Total Mo Prem-2 Tier | 438 | \$164,430 | \$18,930 | \$6,154 | \$189,514 | 0. | 3 1.0 | | |
| | .00 | Ţ.Ţ.,.OO | Ţ. I,000 | ÷=, | Ţ. 20,0. T | | | | |
| 3 Tier | | | | | | | | | |
| 43 Participant (38ee) | 438 | \$375.41 | \$43.22 | \$14.05 | | | | | |
| 44 Participant Plus One | 0 | \$727.06 | \$88.83 | \$27.11 | | 0. | 9 | 0.1 | |
| 45 Participant Plus Family | 0 | \$1,057.70 | \$119.95 | \$37.22 | | 0. | 9 | 2.5 | |
| 46 Total Mo Prem-3 Tier | 438 | \$164,430 | \$18,930 | \$6,154 | \$189,514 | | | | |
| | EVDEDIENCE | DATE | | | | | | | |
| E4 Experience Deried Desires | EXPERIENCE I | | E44 E | - DEDM /Ec*/4 . I | E40*E40/E40 | | | | #050.70 |
| E1 Experience Period Begins: | | 11/1/2012 | | e PEPM (E6*(1+l | , | • | | | \$252.73 |
| E2 Experience Period Ends: | | 10/31/2014 | | e "Using Lagged" | | , | | | \$256.29 |
| E3 Number of Months Experience: | | 24 | | xpected PEPM wi | ANN MIDINK M | rienu | | | 269.26 |
| E4 Enrolled Months | | 9,672 | E17 Credibility | | oriona-*CF | Manual*/4 OF | ٠, | | 90.00% |
| E5 Actual Claims | | 2,075,887 | | Claims Cost = Exp | perience*CF + | - ivianual"(1-CF | , | | \$254.38 |
| E6 Actual PEPM | | \$214.63 | E19 Retention | | | | | | 0.245 |
| E7 Lagged PEPM | | \$217.65 | E20 Commissi | | EDM) | | | | 0.050 |
| E8 Months Trended (mdpt to mdpt) | | 20 | | nium Charged (Pl | | | | | \$354.66 |
| E9 Annual Trend Factor | | 0.103 | E22 Gross ML | R - Medical Loss | Katio | | | | 71.7% |
| E10 Trend from midpt to midpt | | 17.75% | | | | | | | |
| E11 Lagged is this percent over Actual | | 1.4% | | | | | | | |
| E12 Plan or other differential | | 1.000 | | | | | | | |
| E13 Adjustment to incur claims | | 1.000 | | | | | | | |

TABLE A - Claims Premium Table

| Claims | Premium |
|-----------------------|-----------------------|
| \$0 | \$337.00 |
| \$50 | \$332.46 |
| \$100 | \$328.95 |
| \$150 | \$325.47 |
| \$200 | \$322.44 |
| \$250 | \$319.46 |
| \$300 | \$316.47 |
| \$350 | \$313.72 |
| \$400 | \$311.09 |
| \$450 | \$308.45 |
| \$500 | \$305.97 |
| \$750 | \$294.74 |
| \$1,000 | \$285.07 |
| \$1,500 | \$269.16 |
| \$2,000 | \$256.11 |
| \$2,500 | \$245.02 |
| \$3,000 | \$235.43 |
| \$4,000 | \$219.02 |
| \$5,000 | \$205.82 |
| \$7,500 | \$180.17 |
| \$10,000 | \$161.01 |
| \$15,000 | \$132.87 |
| \$20,000 | \$113.80 |
| \$25,000 | \$99.80 |
| \$30,000 | \$88.89 |
| \$35,000 | \$80.28 |
| \$40,000 | \$73.31 |
| \$45,000 | \$67.35 |
| \$50,000 | \$62.45 |
| \$60,000 | \$54.17 |
| \$70,000 | \$47.52 |
| \$80,000 | \$42.23 |
| \$90,000 | \$37.74 |
| \$100,000 | \$34.17 |
| \$125,000 | \$27.22 |
| \$150,000 | \$22.23 |
| \$175,000 | \$18.50 |
| \$200,000 | \$15.63 |
| \$225,000 | \$13.41 |
| \$250,000 | \$11.53 |
| \$300,000 | \$8.67 |
| \$400,000 | \$5.20 |
| \$500,000 | \$3.30 |
| \$1,000,000 | \$0.37 |
| Unlimited | \$0.00 |
| ase rates are for a n | olicy year starting 1 |

base rates are for a policy year starting 12/1/2014

TABLE B - Sample of Plans with Benefit Design Factors

| | | | | OOP | Annual | |
|-----------|---------|-------|----------|----------|-------------|-----------------|
| Med Plan# | Loc | Coins | Ded | (addDed) | Limit | Ben Design Fctr |
| 0 | | | | | | |
| 1 | US | 80% | \$0 | \$2,000 | \$5,000,000 | 1.000 |
| 2 | US | 60% | \$1,000 | \$2,000 | \$5,000,000 | 0.828 |
| 3 | Oversea | 100% | \$0 | \$2,000 | \$5,000,000 | 1.117 |
| 4 | US | 80% | \$500 | \$3,000 | \$5,000,000 | 0.900 |
| 5 | US | 60% | \$1,000 | \$3,000 | \$5,000,000 | 0.797 |
| 6 | Oversea | 100% | \$250 | \$3,000 | \$5,000,000 | 1.017 |
| 7 | US | 80% | \$1,000 | \$4,000 | \$5,000,000 | 0.831 |
| 8 | US | 60% | \$2,000 | \$4,000 | \$5,000,000 | 0.709 |
| 9 | Oversea | 100% | \$500 | \$4,000 | \$5,000,000 | 0.948 |
| 10 | US | 80% | \$2,000 | \$8,000 | \$5,000,000 | 0.728 |
| 11 | US | 60% | \$4,000 | \$8,000 | \$5,000,000 | 0.573 |
| 12 | Oversea | 100% | \$1,000 | \$8,000 | \$5,000,000 | 0.851 |
| 13 | US | 80% | \$5,000 | \$10,000 | \$5,000,000 | 0.585 |
| 14 | US | 60% | \$10,000 | \$10,000 | \$5,000,000 | 0.427 |
| 15 | Oversea | 80% | \$2,500 | \$10,000 | \$5,000,000 | 0.569 |

| | | | | | Annual | Benfit Design Factors - |
|----------|-----|-------|-----|----------|-----------|-------------------------|
| Rx Plan# | Loc | Coins | Ded | OOP | Limit | Maximum Payment |
| 0 | | | | | | |
| 1 | All | 100% | \$0 | No Limit | \$500 | 0.1985 |
| 2 | All | 100% | \$0 | No Limit | \$1,000 | 0.3178 |
| 3 | All | 100% | \$0 | No Limit | \$1,200 | 0.3560 |
| 4 | All | 100% | \$0 | No Limit | \$5,000 | 0.7032 |
| 5 | All | 100% | \$0 | No Limit | \$25,000 | 0.9213 |
| 6 | All | 100% | \$6 | No Limit | Unlimited | 1.0000 |

TABLE C - Area Factors (weighted average by enrollment)

| TABLE C - Area F | actors (weighte | ed average by enrollme | nt) | | |
|---------------------|-----------------|------------------------|--------|---------------------|--------|
| Area | Factor | Area | Factor | Area | Factor |
| AFGHANISTAN | 0.92 | FIJI | 0.92 | NEPAL | 0.92 |
| AFRICA | 0.81 | FINLAND | 1.13 | NETHERLAND ANTILLES | 1.08 |
| AFRICAN | 0.81 | FR. PACIFIC ISLANDS | 0.92 | NETHERLANDS | 0.96 |
| ALBANIA | 1.13 | FRANCE | 1.13 | NEW ZEALAND | 0.92 |
| ALGERIA | | | | NICARAGUA | |
| | 0.81 | FRENCH COMM IN AFRICA | 0.81 | | 1.08 |
| ANDORRA FRENCH | 1.13 | FRENCH GUIANA | 1.08 | NIGER | 0.81 |
| ANDORRA SPANISH | 1.13 | GABON | 0.81 | NIGERIA | 0.81 |
| ANGOLA | 0.81 | GAMBIA | 0.81 | NORTH AMERICA | 1.55 |
| ANTIGUA | 1.08 | GERMANY | 1.13 | NORWAY | 1.13 |
| ARGENTINA | 1.08 | GHANA | 0.81 | OMAN | 1.01 |
| ARMENIA | 1.13 | GIBRALTAR | 1.13 | OTHER CHINA | 1.16 |
| ARUBA | 1.08 | GREECE | 1.13 | PAKISTAN | 0.92 |
| AUSTRALIA | 0.84 | GREENLAND | 1.13 | PANAMA | 1.08 |
| AUSTRIA | 1.13 | | 1.08 | PAPUA NEW GUINEA | 0.92 |
| | | GRENADA | | | |
| AZERBAIJAN | 1.13 | GUADALOUPE | 1.08 | PARUGUAY | 1.08 |
| AZORES | 1.13 | GUAM | 0.92 | PERU | 1.08 |
| BAHAMAS | 1.08 | GUATEMALA | 1.08 | PHILIPPINES | 0.79 |
| BAHRAIN | 1.01 | GUINEA BISSAU | 0.81 | POLAND | 1.13 |
| BANGLADESH | 0.92 | GUINEA REPUBLIC | 0.81 | PORTUGAL | 1.13 |
| BARBADOS | 1.08 | GUYANA | 1.08 | PUERTO RICO | 1.08 |
| BEIJING | 1.55 | HAITI | 1.08 | QATAR | 1.01 |
| BELARUS | 1.13 | HONDURAS | 1.08 | REUNION ISLANDS | 0.81 |
| | 0.96 | | 1.35 | | 1.13 |
| BELGIUM | | HONG KONG | | ROMANIA | |
| BELIZE | 1.08 | HUNGARY | 1.13 | RWANDA | 0.81 |
| BENIN | 0.81 | ICELAND | 1.13 | SAO TOME E PRINCIPE | 0.81 |
| BERMUDA | 1.08 | INDIA | 0.92 | SAUDI | 1.01 |
| BHUTAN | 0.92 | INDONESIA | 0.73 | SAUDI ARABIA | 1.01 |
| BOLIVIA | 1.08 | IRAN | 1.01 | SENEGAL | 0.81 |
| BOSNIA HERZEGOVENA | 1.13 | IRAQ | 1.01 | SEYCHELLES | 0.81 |
| BOTSWANA | 0.81 | IRELAND | 0.96 | SHANGHAI | 1.55 |
| BRAZIL | 1.22 | ISRAEL | 1.55 | SIERRA LEONE | 0.81 |
| BRUNEI | | ITALY | | | |
| | 0.92 | | 1.13 | SINGAPORE | 1.18 |
| BULGARIA | 1.13 | IVORY COAST | 0.81 | SLOVAKIA | 1.13 |
| BURKINO FASCO | 0.81 | JAMAICA | 1.08 | SLOVENIA | 1.13 |
| BURMA | 0.92 | JAPAN | 0.92 | SOLOMON ISLANDS | 0.92 |
| BURUNDI | 0.81 | JERSEY | 1.13 | SOMALI REPUBLIC | 0.81 |
| C&S AMER 1 | 1.08 | JORDAN | 1.01 | SOUTH AFRICA | 0.81 |
| C&S AMER 2 | 1.08 | KAZAKHSTAN | 1.13 | SOUTH AMERICA | 1.08 |
| CAMBODIA | 0.92 | KENYA | 0.81 | SPAIN | 1.13 |
| CAMEROON | 0.81 | KIRIBATI | 0.92 | SRI LANKA | 0.92 |
| CANADA | 1.09 | KOREA | 0.92 | ST LUCIA | 1.08 |
| | | | | | |
| CANARY ISLANDS | 0.81 | KOREA SOUTH | 0.92 | SUDAN | 0.81 |
| CANARY ISLES | 1.13 | KUWAIT | 1.01 | SWAZILAND | 0.81 |
| CAPE VERDE | 0.81 | LAOS | 0.92 | SWEDEN | 1.13 |
| CAYMAN ISLANDS | 1.08 | LATVIA | 1.13 | SWITZERLAND | 1.55 |
| CENTRAL AFRICAN REP | 0.81 | LEBANON | 1.01 | SYRIA | 1.01 |
| CHAD | 0.81 | LEICHTENSTEIN | 1.13 | TAIWAN | 0.92 |
| CHILE | 1.08 | LESOTHO | 0.81 | TANZANIA | 0.81 |
| CIS | 1.13 | LIBERIA | 0.81 | THAILAND | 0.8 |
| COLOMBIA | 1.08 | LIBYA | 0.81 | TOGO REPUBLIC | 0.81 |
| | | LITHUANIA | | | |
| COMORO ISLANDS | 0.81 | | 1.13 | TONGA | 0.92 |
| CONGO | 0.81 | LUXEMBOURG | 1.13 | TRINIDAD & TOBAGO | 1.08 |
| COSTA RICA | 1.08 | MACAU | 0.92 | TUNISIA | 0.81 |
| CROATIA | 1.13 | MADAGASCAR | 0.81 | TURKEY | 1.01 |
| CUBA | 1.55 | MADERIA | 1.13 | IUKKO & CAICUO | 1.08 |
| CYPRUS | 1.13 | MALAWI | 0.81 | UAE | 1.01 |
| CZECH REPUBLIC | 1.13 | MALAYSIA | 0.92 | UGANDA | 0.81 |
| DENMARK | 1.28 | MALDIVES | 0.92 | UKRAINE | 1.13 |
| | | | | | |
| DJIBOUTI | 0.81 | MALI REPUBLIC | 0.81 | UNITED KINGDOM | 1.18 |
| DOMINICA ISLE | 1.08 | MALTA | 1.13 | UNKNOWN | 1.1 |
| DOMINICAN REPUBLIC | 1.08 | MARSHALL ISLANDS | 0.92 | URUGUAY | 1.08 |
| EAST GERMANY | 1.13 | MARTINIQUE | 1.08 | US | |
| ECUADOR | 1.08 | MAURITANIA | 0.81 | UZBEKISTAN | 1.13 |
| EGYPT | 0.81 | MAURITIUS | 0.81 | VANUATA | 0.92 |
| EL SALVADOR | 1.08 | MEXICO | 1.27 | VENEZUELA | 1.08 |
| EQUATORIAL GUINEA | 0.81 | MIDDLE EAST | 1.01 | VIETNAM | 0.92 |
| ESTONIA | 1.13 | MOLDOVA | 1.13 | VIRGIN ISLANDS (Br) | 1.08 |
| | | | | | |
| ETHIOPIA | 0.81 | MONACO | 1.13 | WESTERN SOMOA | 0.92 |
| EUROPE | 1.13 | MONGOLIA | 0.92 | YEMEN | 1.01 |
| EUROPEAN | 1.13 | MOROCCO | 0.81 | YEMEN, REP | 1.01 |
| FALKLAND ISLANDS | 1.08 | MOZAMBIQUE | 0.81 | YUGOSLAVIA | 1.13 |
| FAR EAST 1 | 0.92 | MUSCAT | 1.01 | ZAIRE | 0.81 |
| FAR EAST 2 | 0.92 | NAMERICAN | 1.55 | ZAMBIA | 0.81 |
| FAROE ISLANDS | 1.13 | NAMIBIA | 0.81 | ZIMBABWE | 0.81 |
| | | | | | |

4Ever Life Insurance Company 7 05/20/2015

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TABLE D - Medical Evacuation (interpolated interim values)

| Option | Benefit | Factor |
|---|-----------|----------|
| 1 | \$0 | 0.982 |
| 2 | \$50,000 | 0.990 |
| 3 | \$100.000 | 1.000 |
| 4 | \$150,000 | 1.003 |
| 5 | \$200,000 | 1.004 |
| 6 | \$250,000 | 1.006 |
| 7 | \$300,000 | 1.008 |
| 8 | \$350,000 | 1.009 |
| 9 | \$400,000 | 1.010 |
| 1 2 3 4 5 6 7 8 9 | \$450,000 | 1.011 |
| 11 | \$500,000 | 1.012 |
| 12 | \$550,000 | 1.013 |
| 13 | \$600,000 | 1.014 |
| 14 | \$650,000 | 1.015 |
| 15 | \$700,000 | 1.016 |
| 16 | \$750,000 | 1.017 |
| 17 | \$800,000 | 1.018 |
| 18 | \$850,000 | 1.019 |
| 19 | \$900,000 | 1.020 |
| 20 | \$950.000 | 1.021 |
| 21 | ######## | 1.022 |
| 22 | ######## | Not Avai |

| 22 | ######## | Not Avail | | |
|------|--------------|-----------|------|---------|
| | E - Credib | | | |
| | Participants | | | |
| From | To | Low | Hiah | Formula |
| 50 | 74 | 0% | 30% | 17% |
| 75 | 99 | 0% | 35% | 24% |
| 100 | 124 | 0% | 40% | 29% |
| 125 | 149 | 0% | 45% | 33% |
| 150 | 174 | 0% | 50% | 37% |
| 175 | 199 | 5% | 55% | 40% |
| 200 | 224 | 10% | 60% | 42% |
| 225 | 249 | 15% | 65% | 45% |
| 250 | 274 | 20% | 70% | 47% |
| 275 | 299 | 25% | 75% | 49% |
| 300 | 324 | 30% | 80% | 50% |
| 325 | 349 | 35% | 85% | 52% |
| 350 | 374 | 40% | 90% | 53% |
| 375 | 399 | 45% | 95% | 55% |
| 400 | 424 | 50% | 100% | |
| | | | | 56% |
| 425 | or | 50% | 100% | 57% |

Item 1. Scope & Purpose

This is a new rate filing. The Actuarial Memorandum has been prepared to accompany the previously approved captioned forms filing.

Item 2. Benefit Description

The program is an expatriate health plan that provides hospital/medical/surgical expense benefits to employers for the benefit of employees who are traveling outside the United States for extended periods of time for employer business purposes (generally 3 months or more).

All plans are subject to deductibles and coinsurance and have maximum benefits and other limits consistent with PPACA.

The policy has in-network and out-of-network benefits for coverage in the US and uses a PPO network for these benefits.

Item 3. Renewability

The Policy will continue inforce while the required premiums are paid until the Policy is terminated by either the policyholder or the insurer as allowed in the Policy.

Item 4. Applicability

This filing applies to all new issues and subsequent renewals. There are no existing insureds under this form.

Item 5. Morbidity

This morbidity basis shown in the attached Rate Manual is based on the nationwide experience for this block of business that was written in other states. Current nationwide membership is around 16,000 members and the experienced loss ratio has averaged 69.5% over the last three years.

(\$000)

| Year | Earned Premium | Incurred Claims | Loss Ratio |
|-------|----------------|-----------------|------------|
| 2012 | 17,011 | 12,064 | 70.9% |
| 2013 | 58,868 | 41,739 | 70.9% |
| 2014 | 60,216 | 40,826 | 67.8% |
| Total | 136,095 | 94,629 | 69.5% |

5/20/15

Item 6. Mortality

Mortality is based on US population mortality.

Item 7. Persistency

Given the short term nature of the product, there is no specific persistency assumption used in developing the claim costs.

Item 8. Expenses and Commissions

| 00.0% |
|-------|
| 18.5% |
| 8.0% |
| 2.5% |
| 6.0% |
| 35.0% |
| 1 |

The actual commissions will vary between 0% and 15%. The retention net of commissions also varies by group size shown in the following table.

| Group Size | Retention | Distribution |
|---------------|-----------|--------------|
| 50 | 38.5% | 5.0% |
| 2-399 | 36.5% | 15.0% |
| 400+ | 24.5% | 80.0% |
| | 27.0% | |

Item 9. Marketing Method

Marketing will be to employer groups either through direct response or using agents and brokers.

Item 10. Underwriting

The policies are guarantee issue with no health questions. Policies may be experience rated. The rate manual shows an experience rating calculation. A group can be declined if the travel is to a country of civil unrest or hazardous.

Item 11. Premium Classes

For each employer, rates vary only by tier. The rate is determined by taking the average rate based on the age and gender of the employees, benefit plan provisions (deductible, coinsurance, and lifetime maximum, etc.), area, etc.

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Item 12. Issue Age Limits

None.

Item 13. Area Factors

Rates vary by zip code and nationality as shown in the rate manual.

Item 14. Average Annual Premium

The average annual premium is shown in the Rate Manual worksheet.

Item 15. Number of Insureds

The Company has no insureds at the present time as this is the initial filing.

Item 16. Premium Modalization Rules

Premiums are stated as monthly.

Item 17. Trend Assumption

Medical trend is 10.3% annual. Dental trend is 6 % annual. Vision trend is 4% annual.

Item 18. Claim Liability and Reserves

Claim Reserves and Liabilities will be established by a combination of Lag Studies, case level reserves, and analysis of claim inventories.

Item 19. Active Life Reserves

No Active Life Reserves will be held for this coverage.

Item 20. Minimum Required Loss Ratio

The minimum required loss ratio for this form is 65.0%.

The EXPATRIATE HEALTH COVERAGE CLARIFICATION ACT OF 2014 generally exempts expatriate health plans from the MLR requirements of PPACA for plans written on or after 7/1/15. Prior to that, expatriate plans were allowed a 2x factor to the numerator when calculating the MLR, essentially permitting a minimum standard loss ratio of 42.5% for large-groups expatriate plans in order to meet MLR requirements.

Item 21. Distribution of Business

The anticipated distribution of business is shown on the attached Rate Manual worksheet and is used

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in the calculation of the average premium.

Item 22. Contingency and Risk Margin

The expected margin for profit and contingencies is 6.0% of premium.

Item 23. Experience – Past and Future

As this is a new product, no historical experience is available in this state.

Item 24. Anticipated Loss Ratio

The anticipated loss ratio is 65.0%. The anticipated loss ratio for each year is 65.0%

Item 25. History of Rate Adjustments

This is a new rate filing. There have been no rate adjustments.

Item 26. Proposed Effective Date

These rates are to be effective coincident with approval.

Item 27. Actuarial Certification

I, Randall Jones, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify to the best of my knowledge and judgment, this Actuarial Memorandum and the entire rate filing is in compliance with the applicable laws of the State and with the rules of the Department of Insurance, and complies with Actuarial Standard of Practice No. 8 "Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits" as adopted by the Actuarial Standards Board, and that the benefits provided are reasonable in relation to the proposed premiums based on the standards described above. The premium schedule is not excessive, inadequate or unfairly discriminatory.

Randall S. Jones, FSA, MAAA

Randall & Jaces

President

Sierra Actuarial Services, Inc.

May 20, 2015

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