HM LIFE INSURANCE COMPANY

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

1-800-328-5433

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

Pacific Intercultural Exchange

CERTIFICATE OF COVERAGE

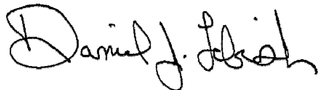
BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

PARTICIPATION CERTIFICATE NO. HMT-1062-I/A-09 (the "Participation Certificate")

Participating Organization or Institution:	**Pacific Intercultural Exchange (the "Organization")**
Participating Organization's or Institution's Effective Date:	July 1, 2009
Eligible Participant:	See Identification Card Issued to Participant
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a "Covered Person," and to **HM Life Insurance Company** as "Insurer." The Participation Certificate will be administered on behalf of the Insurer by the Administrator:" Worldwide Insurance Services, Inc., aka "HTH Worldwide".

This Certificate replaces all certificates previously issued to the Eligible Participant as evidence of coverage under the Organization.



President

Secretary

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SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES

The Classes eligible for coverages available under the Participation Certificate are shown below. The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.

__X__ Class I: Regular, full-time Eligible International Participants of the educational organization or institution.

SCHEDULE OF BENEFITS
TABLE 1

	Limits – Eligible Participant
COVERAGE A – MEDICAL EXPENSES	
Lifetime Maximum Benefit	$1,000,000
Plan Year Maximum Benefits	$250,000
Maximum Benefit per Injury or Sicknesses	$250,000
Deductible	$0 per Injury or Sickness
Plan Year Out-of-Pocket Limit Out-of-Pocket Limit means the amount of Reasonable Expenses for which the Covered Person is responsible after which the Insurer pays 100% of the Reasonable Expenses, subject to the limits and provisions of the Participation Certificate.	After the Covered Person reaches a $2,500 Out-of-Pocket Limit per Plan Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Co-payments, and amounts above the maximums do not apply toward the Out-of-Pocket Limit.
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to $10,000
COVERAGE C – REPATRIATION OF REMAINS	Maximum Benefit up to $15,000
COVERAGE D – MEDICAL EVACUATION	Maximum Lifetime Benefit for all Evacuations up to $50,000
COVERAGE E – BEDSIDE VISIT	Up to a maximum benefit of $2,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person

SCHEDULE OF BENEFITS
TABLE 2

COVERAGE A – MEDICAL EXPENSES	**PPO Plan – In PPO Limits+**	**PPO Plan – Outside PPO Limits**
Physician Office Visits*	100% of Reasonable Expenses after $20 Copayment per visit.	80% of Reasonable Expenses
Inpatient Hospital Services	100% of Reasonable Expenses after $100 Copayment per visit.	80% of Reasonable Expenses
Hospital and Physician Outpatient Services	100% of Reasonable Expenses after $100 Copayment per visit.	80% of Reasonable Expenses

+Payment of Covered Medical Expenses for Preferred Providers is based on the Insurer's negotiated rate. Preferred Providers have agreed to accept the negotiated rate as payment in full.

*All Physician Visit Co-payments for an Injury or Sickness are waived if treatment is received at Recognized Student Health Center or if the initial treatment for an Injury or Sickness is received at Recognized Student Health Center.

If a Covered 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.

If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Preferred Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Preferred Provider.

SCHEDULE OF BENEFITS
TABLE 3
COVERAGE A – MEDICAL EXPENSE BENEFITS

BENEFITS LISTED BELOW ARE SUBJECT TO

1. TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;

2. TABLE 2 PLAN TYPE LIMITS (PPO)

MEDICAL EXPENSES	COVERED PERSON
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to $10,000 Maximum per lifetime for a Maximum period of 30 days per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to $1,000 Maximum per lifetime
Outpatient back and spine treatment (including modalities)	Reasonable Expenses up to $1,000 Maximum per Plan Year with a $50 per visit Maximum and a Maximum of 3 visits per week
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to $1,000 Maximum per Plan Year on an Inpatient basis. Reasonable Expenses up to $50 Maximum per visit subject to a Maximum of 20 visits on an Outpatient basis. This benefit is per Plan Year.
Medical treatment arising from participation in interscholastic or club sports	Reasonable Expenses up to $10,000 Maximum per Plan Year. Injuries from participation in intramural sports are covered as any other Injury.
Medical treatment of Injuries sustained as a result of a covered motor vehicle accident	Reasonable Expenses up to $10,000 Maximum per Plan Year
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to $750 per Plan Year maximum
Outpatient prescription drugs	80% of actual charge up to a maximum of $1,000 per Plan Year
Medical treatment received in the Home Country, if NOT covered by Other Plan	100% of Reasonable Expenses up to $1,000 lifetime maximum

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES

A. **What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Participation Certificate due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit for the Eligible Participant or the Maximum Benefit for an Eligible Dependent stated in Coverage A – Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Co-payments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Participation Certificate Exclusions, the Pre-Existing Condition Limitation, the Recognized Student Health Center provision and to all other limitations and provisions of the Participation Certificate.

B. **Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group Participation Certificate administered by the Administrator immediately prior to the Participation Certificate Effective Date, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance.

If the Covered Person was insured under a group policy previously offered to the Participating Organization or Institution immediately prior to Policy Effective Date of a group policy administered by the Administrator, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance so long as there was continuous coverage from the previous policy to the current Participation Certificate.

1. **Physician office visits.**

2. **Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

   The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

   If Tests and X-rays are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services there is no additional Copayment for these Tests or X-rays. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

3. **Recognized Student Health Centers:**

   If there is a charge for visits to, or medical services, treatments and supplies received from, a Recognized Student Health Center for an Injury or a Sickness, benefits for those visits, medical services, treatments and supplies will be paid at 100% of Reasonable Expenses with no Copayment or Deductible.

   If the Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a Preferred Provider. If the Covered Person uses the Preferred Provider, medical benefits are paid according to the "Inside PPO" schedule. If the Covered Person chooses not to use the Preferred Provider, medical benefits are paid according to the "Outside PPO" schedule. The Copayment and/or Deductible for the initial visit to the Preferred Provider will be waived or reduced if seen by the Recognized Student Health Center first. See Table 2 of the Schedule of Benefits.

C. Additional Covered General Medical Expenses and Limitations: These additional Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

1. **Mammography screenings and pap smears, in accordance with guidelines established by the American Cancer Society**: Coverage provided for two mammography screenings per year when recommended by a Physician for women who have been treated for breast cancer within the last five years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia. (Mammograms are not subject to the deductible/coinsurance provisions.)

2. **Diabetic Supplies/Education:** Coverage shall be provided for the following equipment and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes, if medically appropriate and prescribed by a physician: blood glucose monitors and blood glucose monitors for the legally blind, test strips for glucose monitors and/or visual reading, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, and oral agents for controlling blood sugar and therapeutic/molded shoes for the prevention of amputation.

   Benefits will also be provided for diabetes self-management education and treatment of the diabetic condition, including information on the management of diabetes. Benefits shall be limited to visits Medically Necessary upon diagnosis of diabetes by a Physician or a significant change in the Insured Person's symptoms or conditions which necessitate changes in the Insured Person's self management; and upon determination of a Physician the re-education or refresher education is necessary. Diabetes self-management education shall be provided by a Physician.

   Benefits shall be subject to all deductible, co-payment, coinsurance, limitations, or any other provisions of the Participation Certificate.

3. **Pediatric Preventive and Primary Care Services**: Coverage shall be provided for pediatric preventive care for dependent children from birth to age 19. As used here, "pediatric preventive 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 from birth through age 19. Benefits shall not be provided for pediatric preventive care services that are paid for or offered free of charge by the state of Rhode Island or for the cost of biologicals used for vaccinations.

4. **Cranial Prosthetics:** Coverage shall be provided for scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia Benefits shall be subject to the same limitations and guidelines as other prosthesis, and that it will not exceed an amount of three hundred fifty dollars ($350) per Covered Person member per year, exclusive of any deductible.

5. **Home Health Care:** Coverage shall be provided for home health care to include the following services as needed: physical or occupational therapy as a rehabilitative service, respiratory service, speech therapy, medical social work, nutrition counseling, prescription drugs and medication, medical and surgical supplies, such as dressings, bandages, and casts, minor equipment such as commodes and walkers, laboratory testing, x-rays and E.E.G. and E.K.G. evaluations.

   The home health care program shall be formulated and supervised by the Covered Person's Physician and shall not exceed 6 home or office Physician's visits per month; 3 nursing visits per week; and home health aide visits up to 20 hours per week. Coverage shall not include services in connection with communicable diseases and/or nervous, emotional and mental illness. As used here, "home health care" means a Medically Necessary program to reduce the length of a Hospital stay or to delay or eliminate a Medically Necessary Hospital admission.

6. **Early Intervention Services:** Coverage shall be provided for early intervention services. Coverage shall be limited to a benefit of $5,000 per dependent child Participation Certificate or calendar year and shall not be subject to deductibles and coinsurance factors. Any amount paid by an Insurer for a dependent child not be applied to any annual or lifetime maximum benefit contained in the Participation Certificate. As used here, "early intervention services" means, but is not to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, services, and assistive technology services and devices for dependents from birth to age three (3) who are certified by the department of human services as eligible for services under part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

7. **Hearing Aids:** Coverage shall be limited to $1,500 per individual hearing aid, per ear, every three years per Insured Person under the age of nineteen years and $700 per individual hearing aid, per ear, every three years per Insured Person of the age of nineteen years and older. As used this, "hearing aid" 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.

8. **Human Leukocyte Antigen Testing:** Coverage shall be provided for the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility that is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. § 263a, as it may be from time to time amended. At the time of the testing, the Covered Person being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program. This benefit may limit each Covered Person to one of these testings per lifetime.

9. **Infertility:** Coverage shall be provided for 80% of Medically Necessary expenses of diagnosis and treatment of infertility for women between the ages of (25) and forty (40) years. For purposes here, "infertility" means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of two years.

10. **Lyme Disease:** Coverage shall be provided for diagnostic testing and long-term antibiotic treatment of chronic lyme disease when determined to be medically necessary and ordered by a physician acting in accordance with chapter 37.5 of title 5 entitled "lyme disease diagnosis and treatment" after making a thorough evaluation of the patient's symptoms, diagnostic test results and response to treatment. Treatment otherwise eligible for benefits pursuant to this section shall not be denied solely because such treatment may be characterized as unproven, experimental, or investigational in nature.

11. **Mental Illness and Substance Abuse:** Coverage shall be provided for the medical treatment of mental illness and substance abuse, including Inpatient hospitalization, partial hospitalization provided in a Hospital or any other licensed facility, intensive Outpatient services, Outpatient services and community residential care services for substance abuse treatment.

    Outpatient services, with the exception of Outpatient medication visits, shall be limited to 30 visits in any calendar year; however, Outpatient services for substance abuse treatment shall be limited to 30 hours in any calendar year. Community residential care services for substance abuse treatment shall be limited to 30 days in any calendar year; and detoxification benefits shall be limited to 5 detoxification occurrences or 30 days in any calendar year, whichever comes first. Coverage shall not include methadone maintenance services or community residential care services for mental illnesses other than substance abuse disorders.

    For purposes here, the following definitions shall apply:

    "Mental illness" means any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness, provided, however, that tobacco and caffeine are hereby excluded from the definition of "substance" for the purposes here. "Mental illness" shall not include: (a) mental retardation, (b) learning disorders, (c) motor skills disorders, (f) communication disorders, and (e) mental disorders classified as "V" codes.

    "Outpatient services" means office visits which provide for the treatment of mental illness and substance abuse.

"Community residential care services" shall mean those facilities as defined and licensed in accordance with chapter 24 of title 40.1.

Notwithstanding anything in this certificate to the contrary, coverage for expenses incurred due to mental illness or substance abuse will be covered the same as any other Sickness.

12. **New Cancer Therapies:** Coverage shall be provided for new cancer therapies still under investigation.

13. **Off Label use for Cancer:** If coverage for outpatient prescription drugs is provided, benefits will not be denied for any drug used for the treatment of cancer on the grounds that the drug has not been approved by the FDA for that indication, provided that the drug is recognized for treatment of that indication in one of the standard reference compendia, or in the medical literature. The prescribing physician shall submit to the documentation supporting the proposed off-label use or uses, to the Insurer if requested.

14. **Tobacco Cessation:** If coverage for outpatient prescription drugs is provided, coverage shall be provided for the smoking cessation treatment. As used here, smoking cessation treatment includes the use of an over-the-counter (OTC) or prescription US Food and Drug Administration (FDA) approved nicotine therapy, when recommended and prescribed by a prescriber who holds prescriptive privileges in the state in which they are licensed, and used in combination with an annual outpatient benefit of eight one-half hour smoking cessation counseling sessions provided by a qualified practitioner for each Covered Person. Smoking cessation treatment may be further defined through regulation promulgated by the health insurance commissioner.

D. Home Country Coverage (While Insured): Expenses incurred within the Covered Person's Home Country while insured under the Participation Certificate will be considered as Covered Medical Expenses up to the limits stated in the Schedule of Benefits.

SECTION 3
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered 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 Covered Person due to any one Accident.

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

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

SECTION 4
COVERAGE C – REPATRIATION OF REMAINS BENEFIT

If a Covered 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 Participation Certificate. However, if the Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered 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 Plan Administrator before the body is prepared for transportation.

SECTION 5
COVERAGE D – MEDICAL EVACUATION BENEFIT

If a Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services, while traveling outside of his/her home country, and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the nearest appropriate medical facility. This medically-supervised evacuation will be to the nearest medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered 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 Covered 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 Covered Person is a minor or if the Covered 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 Covered 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 Covered Person's point of origin, if necessary.

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

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

The combined benefit for all necessary evacuation services is listed in Table 1 of the Schedule of Benefits.

SECTION 6
COVERAGE E – BEDSIDE VISIT BENEFIT

If a Covered Person is Hospital Confined due to an Injury or Sickness for more than 7, is likely to be hospitalized for more than 7 days or is in critical condition, 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 hotel accommodations in, the place of the Hospital Confinement for one person designated by the Covered 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 Covered Persons on that trip. The determination of whether the Covered Member will be hospitalized for more than 7 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.

SECTION 7
LIMITATIONS

A. Pre-Existing Condition Limitation

The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first one (1) year of coverage, except as follows: The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the first one (1) year of coverage, subject to a maximum benefit of $500. After the Covered Person has been covered under the Policy for one (1) year, Pre-Existing Conditions will be covered the same as any other Injury or Sickness; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.

This limitation does not apply to a newly adopted child of an Eligible Participant or to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.

SECTION 8
GENERAL PARTICIPATION CERTIFICATE EXCLUSIONS

Unless specifically provided for elsewhere under the Participation Certificate, the Participation Certificate does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Expenses incurred in excess of Reasonable Expenses.
2. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health. This exclusion does not apply to services in connection with pediatric preventive care.
3. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury. This exclusion does not apply to hearing aids.
5. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
6. Elective termination of pregnancy.
7. Expenses incurred as a result of pregnancy that is not covered.
8. For diagnostic investigation or medical treatment for fertility or birth control.
9. Expenses incurred for Injury resulting from the Covered Person's being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
10. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
11. Organ or tissue transplant.
12. Participating in an illegal occupation or committing or attempting to commit a felony.
13. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
14. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Participation Certificate.
16. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, unless otherwise noted.
17. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
18. Diagnosis and treatment of acne and sebaceous cyst.
19. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
20. Self-inflicted Injuries while sane or insane; suicide, or any attempt thereat while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
21. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion; or acts of terrorism.
22. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
23. Loss arising from
    a. participating in any professional sport, contest or competition;
    b. skin/scuba diving, sky diving, hang gliding, bungee jumping.
24. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
25. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

SECTION 9
DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Participation Certificate, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Participation Certificate.

Age means the Covered Person's attained age.

Alcohol Abuse means any pattern of pathological use of alcohol 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.

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Reasonable Expenses for Medically Necessary treatment. The percentage the Insurer pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

Copayment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.

Country of Assignment means the country for which the Eligible Participant has a valid visa, if required, and in which he/she is undertaking an educational activity.

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Participation Certificate; and incurred while the Covered Person's insurance is in force under the Participation Certificate, except as stated in the Extension of Benefits provision.

A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section 2.

Covered Person means an Eligible Participant as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Participation Certificate.

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person on a per Injury or per Sickness basis before certain benefits are payable under the Participation Certificate. The Deductible Amounts are stated in the Schedule of Benefits.

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.

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Participant means a person who:

1. Is engaged in international educational activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:

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

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

Experimental or Investigative 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 Investigative.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable.

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the Participation Certificate. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

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

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

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

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Non-hospital Residential Facility means a facility certified by the District or by any state or territory of the United States as a qualified non-hospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. The term "non hospital residential facility" includes any facility operated by the District, any state or territory, or the United States, to provide these services in a residential setting.

Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Out-of-Pocket Limit means the amount of Reasonable Expenses which the Covered Person must pay after which the Insurer pays 100% of the reasonable Expenses, subject to the limits and provisions of the Participation Certificate.

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician's office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Participation Certificate and which has been accepted by the Insurer for coverage under the Participation Certificate.

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Physiotherapy means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

Participation Certificate Year means the period beginning on the Participating Organization's or Institution's effective date. It includes the period beginning on the date a Covered Person's coverage under the Participation Certificate starts. It ends on the date the Covered Person's insurance under the Participation Certificate ends.

Preferred Provider means a Hospital, Physician, or other health care provider who has agreed to participate in the PPO and who has agreed to accept negotiated rates for charges for Covered Medical Expenses. Preferred Providers have agreed to accept the negotiated rate as payment in full.

Preferred Provider Organization (PPO) means the network(s) of Preferred Providers stated on the Covered Person's identification card.

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received up to one year prior to the Covered Person's effective date of coverage.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students for a minimum of 10 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider.

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." or "R. P.N." after his/her name. Coverage will be provided for the services of a licensed midwife (pursuant to § 27-18-31) and certified counselors and therapist (pursuant to § 27-18-35).

Sickness means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Participation Certificate.

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
    a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
    b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

Written Request means a request on any form provided by the Administrator for particular information.

11:59:59 p.m. means 11:59:59 p.m. at the Covered Person's location.

12:00:01 a.m. means 12:00:01 Eastern Prevailing Time in Washington, DC.

SECTION 10
EXTENSION OF BENEFITS

No benefits are payable for medical treatment benefits after the Covered Person's insurance terminates. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

SECTION 11
EXCESS COVERAGE

The Insurer will reduce the amount payable under the Participation Certificate to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Participation Certificate is secondary coverage to all other policies.

SECTION 12
ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1—Eligible Classes. He/she must not be insured under the Participation Certificate as a dependent. When both spouses are insured as Eligible Participants under the Participation Certificate, only one spouse shall be considered to have any Eligible Dependents.

Enrollment for Coverage: An Eligible Participant will be eligible for coverage under the Participation Certificate subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Organization, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Participation Certificate; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date shown on the Insurance Identification Card, if any;
4. The date the requirements in Section 1 – Eligible Classes are met; or
5. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

For Transfers Only: If a Covered Person transfers from a Group which has coverage under a policy issued on the same form as this plan of insurance to another Group which also has coverage under the same policy form, or transfers from one plan to another under the same policy, and coverage is continuous, then coverage is continued between the two plans of insurance. A Covered Person will be covered under the newer plan for medical conditions which first arise on or after the transfer date. A Pre-Existing Condition will not be covered under the newer plan until the benefit period expires for such condition under the prior plan (the plan under which the Covered Person was insured prior to the date of transfer). At that time, the Pre-Existing Condition will be covered under the newer plan. Benefit payments for Pre-Existing Conditions shall be the lesser of:

1. The unused portion of the maximum benefit applicable to the covered medical condition under the prior plan; or
2. The maximum benefit applicable to the covered medical condition under this plan.

Both 1 and 2 above are subject to the benefit periods, Deductibles, and Coinsurance as defined in the respective policies.

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Participation Certificate terminates;
2. The Participating Organization's or Institution's Termination Date;
3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
4. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
5. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage or if the enrollment form contained inaccurate or misleading information.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

An Eligible Participant shall receive no less than 30 days notice from the Insurer that a child covered as a dependent is about to lose his or her coverage as a result of reaching the maximum age for a Dependent child. Such notice shall also disclose that the child will only continue to be covered upon documentation being provided of current full or part time enrollment in a post-secondary educational institution or that the child may purchase a conversion Participation Certificate if he or she is not an eligible student.

An Eligible Participant shall annually provide proof of a child's current college full and part time enrollment to the Insurer in order to maintain the child's coverage beyond the maximum age for a Dependent child.

The Insurer may require proof disability as from a Physician of such disability, but not more than once a Plan Year.

Conversion Provisions
If an Eligible Participant's coverage terminates, he/she may have the right to purchase an individual conversion policy as outlined below. The Participating Organization or Institution is responsible to provide an Eligible Participant with information regarding his/her options. Evidence of insurability is not required.

There is no right of conversion if:
1. the termination of coverage occurred because the Participating Organization or Institution or the Insured Participant failed to pay any required premium or any discontinued group coverage was replaced by similar group coverage within 31 days of the discontinuance; or
2. an Eligible Participant is or could be covered by Medicare; or
3. an Eligible Participant has similar benefits under another group plan whether insured or uninsured; or
4. an Eligible Participant is eligible for similar benefits under another group plan whether insured or uninsured; or
5. similar benefits are provided for or available to the Insured Participant under any state or federal law.

In addition, there is no right to conversion if an Eligible Participant has similar benefits under an individual policy, or he/she is eligible for similar benefits under another group plan whether insured or uninsured.

Conversion for Eligible Persons
If the coverage of an Eligible Person terminates he/she may be eligible to convert his/her group coverage to a conversion policy. In order to be eligible for conversion, an Eligible Person must have been terminated for any reason other than eligibility for Medicare.

Upon termination of coverage, the Participating Organization or Institution is responsible to notify the affected individual of this conversion right. Written application and the first premium payment for the conversion policy must be received by the Insurer within 31 days of the termination of this group plan.

Application for conversion membership does not require a health statement. A conversion policy will be effective on the day after termination of coverage under the group plan. You will be given credit for any satisfaction under the group plan of waiting periods or limitations for any Preexisting Condition.

SECTION 13
CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 20 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Participation Certificate by submitting, within the time fixed in the Participation Certificate for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Participation Certificate provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided
1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy will be paid not more than 60 days after receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Participation Certificate which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to $1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

All benefits payable under the Participation Certificate shall be payable to the Insured or to his/her designated beneficiary or beneficiaries, or to his/her estate. If the Insured is a minor, benefits may be payable to his/her parents, guardian, or other person actually supporting him/her, or to a person or persons upon whom such minor is chiefly dependent upon for support and maintenance.

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Participation Certificate and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

SECTION 14
GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Organization consists of the Participation Certificate, this Certificate, the application of the Organization and the application of the Participating Organization or Institution, copies of which are attached to and made a part of the Participation Certificate. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Participation Certificate, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Participation Certificate will be valid unless evidenced by an endorsement or amendment of the Participation Certificate, signed by one of the Insurer's officers and delivered to the Organization.

Incontestability: The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Participation Certificate has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Participation Certificate unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after 2 years from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover on the Participation Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Participation Certificate. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Participation Certificate which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Participation Certificate.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Participation Certificate unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers' compensation. The Participation Certificate does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Participation Certificate due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Participation Certificate against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Participation Certificate for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Participation Certificate in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Participation Certificate to the extent of the overpayment.

Currency: All premiums for and claims payable pursuant to the Participation Certificate are payable only in the currency of the United States of America.

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

The Covered 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 Covered Person's written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Covered 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 Covered 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:

HM Life Insurance Company
120 Fifth Avenue
Fifth Avenue Place
Pittsburgh, PA 15222

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 Covered 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 Covered Person's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.