



**University System of Georgia**  
 CERTIFICATE OF COVERAGE

GROUP STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. U-2058-04 ("the Policy")

Participating Organization or Institution: Georgia Board of Regents  
 Participating Organization's or Institution's Effective Date: August 1, 2004  
 Eligible Participant: See Identification Card Issued to Participant  
 Eligible Dependents: 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 UNICARE Life & Health Insurance Company as "Insurer." The Policy will be administered on behalf of the Insurer by **Worldwide Insurance Services d/b/a HTH Worldwide (hereafter HTH)**.

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



PRESIDENT

Table of Contents

|            |  |         |
|------------|--|---------|
| SECTION 1  | <a href="#">SCHEDULE OF BENEFITS – Eligible Classes</a>  | Page 2  |
|            | <a href="#">SCHEDULE OF BENEFITS – TABLE 1</a>   | Page 2  |
|            | <a href="#">SCHEDULE OF BENEFITS – TABLE 2 Coverage A – Medical Benefits</a>                       | Page 3  |
|            | <a href="#">SCHEDULE OF BENEFITS – TABLE 3 Coverage A – Medical Expense Benefits</a>               | Page 3  |
| SECTION 2  | <a href="#">DESCRIPTION OF COVERAGES – Coverage A – Medical Expenses</a>                           | Page 4  |
| SECTION 3  | <a href="#">DESCRIPTION OF COVERAGES – Coverage B – Accidental Death and Dismemberment Benefit</a> | Page 6  |
| SECTION 4  | <a href="#">DESCRIPTION OF COVERAGES – Coverage C – Repatriation of Remains Benefit</a>            | Page 6  |
| SECTION 5  | <a href="#">DESCRIPTION OF COVERAGES – Coverage D – Medical Evacuation Benefit</a>                 | Page 7  |
| SECTION 6  | <a href="#">DESCRIPTION OF COVERAGES – Coverage E – Bedside Visit Benefit</a>                      | Page 7  |
| SECTION 7  | <a href="#">PRE-EXISTING CONDITION LIMITATION</a>  | Page 7  |
| SECTION 8  | <a href="#">GENERAL POLICY EXCLUSIONS</a>  | Page 7  |
| SECTION 9  | <a href="#">DEFINITIONS</a>  | Page 8  |
| SECTION 10 | <a href="#">EXTENSION OF BENEFITS</a>  | Page 11 |
| SECTION 11 | <a href="#">COORDINATION OF BENEFITS (COB)</a>   | Page 11 |
| SECTION 12 | <a href="#">ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE</a>                                    | Page 12 |
| SECTION 13 | <a href="#">COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN</a>                                   | Page 14 |
| SECTION 14 | <a href="#">PREMIUM</a>  | Page 14 |
| SECTION 15 | <a href="#">CLAIM PROVISIONS</a>   | Page 14 |
| SECTION 16 | <a href="#">GENERAL PROVISIONS</a>   | Page 15 |

**SECTION 1  
SCHEDULE OF BENEFITS  
ELIGIBLE CLASSES**

The Classes eligible for coverages available under the Policy 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.

- Class I: All regular, full-time Eligible Participants of the educational organization or institution and their Eligible Dependents.
- Class II: All part-time Eligible Participants of the educational organization or institution and their Eligible Dependents.
- Class III: Mandatory - Eligible Participants.
- Class IV: Voluntary - Eligible Dependents - Spouse.
- Class V: Voluntary - Eligible Dependents - Child.

All benefits and limits are stated per Covered Person

**SCHEDULE OF BENEFITS – TABLE 1**

|   | Limits<br>Eligible Participant   | Limits<br>Spouse   | Limits<br>Child  |
|---|--|--|--|
| <b>COVERAGE A –<br/>MEDICAL EXPENSES</b>  |  |  |  |
| Lifetime Maximum Benefit  | \$1,000,000  | \$1,000,000  | \$1,000,000  |
| Policy Year Maximum Benefits  | \$1,000,000  | \$1,000,000  | \$1,000,000  |
| Maximum Benefit per Injury or<br>Sicknesses   | \$500,000  | \$500,000  | \$500,000  |
| Deductible  | \$0 per Injury or Sickness   | \$0 per Injury or Sickness   | \$0 per Injury or Sickness   |
| <b>Policy Year Out-of-Pocket Limit</b><br>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 Policy. | After the Covered Person reaches a \$2,500 Out-of-Pocket Limit per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Copayments and amounts above the maximums do not apply toward the Out-of-Pocket Limit. | After the Covered Person reaches a \$2,500 Out-of-Pocket Limit per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Copayments and amounts above the maximums do not apply toward the Out-of-Pocket Limit. | After the Covered Person reaches a \$2,500 Out-of-Pocket Limit per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Copayments and amounts above the maximums do not apply toward the Out-of-Pocket Limit. |
| <b>COVERAGE B –<br/>ACCIDENTAL DEATH AND<br/>DISMEMBERMENT</b>  | Maximum Benefit:<br>Principal Sum up to \$10,000   | Maximum Benefit:<br>Principal Sum up to \$5,000  | Maximum Benefit:<br>Principal Sum up to \$1,000  |
| <b>COVERAGE C –<br/>REPATRIATION OF REMAINS</b>   | Maximum Benefit up to \$30,000   | Maximum Benefit up to \$30,000   | Maximum Benefit up to \$30,000   |
| <b>COVERAGE D –<br/>MEDICAL EVACUATION</b>  | Maximum Lifetime Benefit for all Evacuations up to \$100,000   | Maximum Lifetime Benefit for all Evacuations up to \$100,000   | Maximum Lifetime Benefit for all Evacuations up to \$100,000   |
| <b>COVERAGE E –<br/>BEDSIDE VISIT</b>   | Up to a maximum benefit of \$1,500 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  | Up to a maximum benefit of \$1,500 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  | Up to a maximum benefit of \$1,500 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**

|   | <b>PPO Plan – In PPO Limits</b>                            | <b>PPO Plan – Outside PPO Limits</b> |
|---|--|--------------------------------------|
| <b>Physician Office Visits*</b>                   | 100% of Reasonable Expenses after \$15 Copayment per visit | 80% of Reasonable Expenses           |
| <b>Inpatient Hospital Services</b>                | 100% of Reasonable Expenses after \$50 Copayment per visit | 80% of Reasonable Expenses           |
| <b>Hospital and Physician Outpatient Services</b> | 100% of Reasonable Expenses after \$50 Copayment per visit | 80% of Reasonable Expenses           |

\*All Physician Visit Copayments 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**

- TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS; AND**
- TABLE 2 PLAN TYPE LIMITS (PPO)**

| <b>MEDICAL EXPENSE</b>  | <b>Limits – Covered Person</b>  |
|---|---|
| <b>Maternity Care for a Covered Pregnancy</b>   | Reasonable Expenses   |
| <b>Inpatient treatment of mental and nervous disorders including drug or alcohol abuse</b>  | Reasonable Expenses up to for a maximum period of 30 days per lifetime  |
| <b>Outpatient treatment of mental and nervous disorders including drug or alcohol abuse</b>                                       | Reasonable Expenses up to \$1,000 Maximum per lifetime  |
| <b>Outpatient back and spine treatment (including modalities)</b>   | Reasonable Expenses up to \$1,000 Maximum per Policy Year with a \$50 per visit Maximum   |
| <b>Treatment of specified therapies, including acupuncture and Physiotherapy</b>  | Reasonable Expenses for up to 30 days Maximum per Policy Year on an Inpatient basis. Reasonable Expenses up to \$2,500 Maximum per Policy Year on an Outpatient basis |
| <b>Therapeutic termination of pregnancy</b>   | Reasonable Expenses up to \$3,000 Maximum per Policy Year   |
| <b>Elective termination of pregnancy</b>  | Reasonable Expenses up to \$500 Maximum per Policy Year   |
| <b>Routine nursery care of a newborn child of a covered pregnancy</b>   | Reasonable Expenses up to \$1,000 Maximum per Policy Year   |
| <b>Annual cervical cytology screening for women 18 and older</b>  | Reasonable Expenses   |
| <b>One Low dose mammography screening per year, and/or one baseline mammogram and one mammogram per year for a woman at risk.</b> | Reasonable Expenses   |
| <b>Medical treatment arising from participation in intercollegiate, interscholastic sports, intramural or club sports</b>         | Reasonable Expenses up to \$10,000 Maximum per Policy Year  |
| <b>Repairs to sound, natural teeth required due to an Injury</b>  | 100% of Reasonable Expenses up to \$1,000 per Policy Year maximum/\$250 per tooth   |
| <b>Outpatient prescription drugs including oral and Norplant contraceptives</b>   | 80% of actual charge  |
| <b>Medical treatment received in the Home Country, if NOT covered by Other Plan</b>   | 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 Policy 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 of \$500,000 per Injury or Sickness for the Eligible Participant or the Maximum Benefit of \$500,000 per Injury or Sickness for an Eligible Dependent. Benefits are subject to the Deductible Amount, Coinsurance and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, the Recognized Student Health Center provision and to all other limitations and provisions of the Policy.

**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 date the Confinement ends.

If the Covered Person was insured under a group policy administered by HTH immediately prior to the Policy 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 a Participating Organization or Institution immediately prior to Policy Effective Date of a group policy administered by HTH, 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 policy.

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.

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 provider. Medical benefits are paid according to the "Inside PPO" schedule.

**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. **Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Conception must have occurred while the Covered Person was insured under the Policy. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
- b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a) Parental education;
- b) Assistance and training in breast or bottle feeding; and

- c) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.
2. **Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.
  3. **Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:
    - a) Female Covered Persons, including those at risk, are allowed one baseline mammogram;
    - b) Female Covered Persons are allowed a screening mammogram annually

A mammogram is also covered whenever ordered by a physician for a woman at risk, which includes a woman (a) who has a personal history of breast cancer; (b) who has a personal history of biopsy proven benign breast disease; (c) whose grandmother, mother, sister or daughter has had breast cancer; or (d) who has not given birth prior to age 30.
  4. **Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.
  5. **Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.
  6. **Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.
  7. **Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered 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.
  8. **Outpatient Prescription Drugs:** If coverage for outpatient prescription drugs is provided in Schedule of Benefits Table 3, such coverage will include FDA approved prescription contraceptives, including injectable and implantable methods administered in a Physician's office.
  10. **Surveillance Tests For Ovarian Cancer:** Coverage shall include surveillance tests for covered women age 35 and older at risk of ovarian cancer. As used here, "surveillance tests" means annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.
  11. **Certain Dental Procedures on Children:** Coverage is provided for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting, when the clinical status or underlying medical condition of the Covered Person requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or surgery center setting.
 

This benefit shall apply only to general anesthesia and associated facility charges and for only the following Covered Persons:

    1. 7 years of age or younger or is developmentally disabled;
    2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Covered Person; or
    3. An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

No benefits are payable for the dental procedure itself or the professional fee of the dentist. Coverage for anesthesia and associated facility charges shall be subject to all other terms and condition of the Policy that apply generally to other benefits.

In addition, no coverage is provided for anesthesia or related facility charges for dental procedures that would ordinarily require general anesthesia, except for those Covered Persons described above.
  12. **Chlamydia Testing:** Coverage shall include one annual Chlamydia screening test for covered females under age 30.
  13. **Routine Patient Care for Dependent Children:** Coverage shall include expenses incurred for routine patient care costs in providing goods and services to an Eligible Dependent in connection with an approved clinical trial program for the treatment of children's cancer, as defined in Ga.St.§33-25-59.1(a)(2), if the Eligible Dependent: (a) was diagnosed with cancer prior to reaching age 19; (b) is enrolled in such clinical trial program; and (c) the Eligible Dependent is not otherwise eligible for benefits, payments

or reimbursements from any other third party payors or other similar sources, subjects to co-payments, deductibles and coinsurance.

14. **Athletic Trainer Services:** Coverage shall include the services of a licensed qualified athletic trainer which are within the lawful scope of a licensed qualified athletic trainer or a licensed doctor. As used here Qualified athletic trainer means a person who:
1. meets the athletic training curriculum requirements of a college or university approved by the state licensing board and provides proof of graduation; or
  2. has a degree in physical therapy or corrective therapy with at least a minor in physical education or health which included a basic athletic training course and who has spent at least 2 academic years working under the direct supervision of an approved athletic trainer.

Benefits for services under this provision will be subject to all other terms of the group policy.

15. **Autism:** Coverage shall include covered expenses incurred for the treatment of autism to the same extent as for any other covered neurological disorder. Benefits are payable subject to all conditions and limitations of the policy. For purposes of this provision, "Autism" means a developmental neurological disorder, usually appearing in the first 3 years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

16. **Child Preventive and Primary Care Services:** The coverage set forth in Section 2, Description of Coverages, for child preventive care will not be subject to a deductible for covered children through age 5.

- D. **Home Country Coverage (While Insured):** Expenses incurred within the Covered Person's Home Country while insured under the Policy 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.

If the Covered Person and the designated beneficiary have died and there is not sufficient proof that they died other than simultaneously, the accidental death proceeds will be distributed as if the Covered Person survived the beneficiary.

### SECTION 4 COVERAGE C – REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the repatriation of the Covered Person's 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 or visitation or funeral expenses. Any expenses for repatriation of remains require the Insurer's or HTH's prior approval.

If an Injury or a Sickness results in the Covered Person's loss of life outside his/her Home Country, the Insurer will pay the Reasonable Expense incurred for cremation or for preparation of the body for burial in, and for transportation of the body to, the Home Country up to the maximum stated for this benefit in Table 1 of the Schedule of Benefits. Payment of this benefit is subject to the Limitations and Conditions on Eligibility for Benefits. No benefit is payable if the death occurs after the Period of Coverage Termination Date. However, if the Covered Person is Hospital Confined on the Period of Coverage Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Period of Coverage Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by either the Insurer or HTH before the body is prepared for transportation.

**SECTION 5**  
**COVERAGE D – MEDICAL EVACUATION BENEFIT**

If a Covered Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to the lifetime Maximum Limit for all medical evacuations shown in Table 1 of the Schedule of Benefits, for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Covered Person's Home Country. Transportation must be by the most direct and economical route. However, before the Insurer makes any payment, it requires written certification by the attending Physician that the evacuation is Medically Necessary. Any expenses for medical evacuation require the Insurer's or HTH's prior approval. No benefits are payable under any other provision of the Policy for expense incurred by the Covered Person on and after the date of the evacuation.

With respect to this provision only, the following is in lieu of the Policy's Extension of Benefits provision: No benefits are payable for Reasonable Expenses incurred after the date the Covered Person's insurance under the Policy 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.

**SECTION 6**  
**COVERAGE E – BEDSIDE VISIT BENEFIT**

**Bedside Visit Benefit:** If the Covered Person is Hospital Confined due to an Injury or Sickness for more than seven (7) days while traveling outside his/her Home Country, the Insurer will pay up to a maximum benefit of \$1,500 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 person designated by the Covered Person. 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. No more than one (1) visit may be made during any 12 month period. No benefits are payable under this provision prior to the end of the seven (7) day Hospital Confinement. No benefits are payable unless the trip is approved in advance by HTH.

**SECTION 7**  
**PRE-EXISTING CONDITION LIMITATION**

The Insurer does not pay benefits for loss due to a Pre-Existing Condition during the first 6 months of coverage.

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

**SECTION 8**  
**GENERAL POLICY EXCLUSIONS**

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

1. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health.
2. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
3. 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.
4. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
5. For medical treatment for infertility, fertility, or birth control.
6. Expenses incurred in excess of Reasonable Expenses.
7. 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.
8. 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.
9. Organ or tissue transplant.
10. Participating in an illegal occupation or committing or attempting to commit a felony.
11. 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.)
12. 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.
13. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
14. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia. Coverage for TMJ Dysfunction will be limited to surgical and nonsurgical treatment of the TMJ, but will not include cosmetic or elective orthodontic or periodontic care or general dental care.
15. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.

16. Diagnosis and treatment of acne and sebaceous cyst.
17. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
18. **Intentionally** self-inflicted Injuries while sane or insane; suicide, or any attempt thereof 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.
19. 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.
20. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
21. Loss arising from participation in professional sports, scuba diving, hang gliding, parachuting or bungee jumping.
22. 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.
23. 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.
24. Expenses incurred as a result of pregnancy that is not covered.

## SECTION 9 DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, 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 Policy.

**Administrator** is Worldwide Services d/b/a HTH Worldwide (hereafter HTH).

**Age** means the Covered Person's attained age.

**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 period of time a Covered Person spends as an Inpatient in a Hospital due to the same or related cause. Periods of hospital confinement which are due to the same or related causes and which are separated by intervals of less than 30 days will be considered as one period of confinement.

**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 passport and, if required, a visa, 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 Policy; and incurred while the Covered Person's insurance is in force under the Policy, 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 and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

**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 Policy. The Deductible Amounts are stated in the Schedule of Benefits. If the Deductible Amount is determined on a Calendar Year or Policy Year basis, then any amount of Covered Expenses that

are incurred and applied toward the Deductible Amount in the last 3-month period of the prior Calendar Year or Policy Year will be applied toward the Deductible Amount for the next following Calendar Year or Policy Year.

**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 Dependent:** An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 19 who are chiefly dependent upon the Eligible Participant for support and maintenance. Upon reaching the limiting age/ age 19, the age limitation on a Covered Child will be increased to age 25 as long as such child is dependent on the Eligible Participant, and the child in each calendar year after reaching the limiting age/age 19 for such dependent, has been enrolled for 5 calendar months or more as a full-time student at a post-secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to sickness or injury. Termination based on the limiting age/age 19 will not be applied to a child who is mentally retarded or physically disabled provided such child remains dependent on the Eligible Participant. The term "child/children" includes a natural child, a legally adopted child, a stepchild, a dependent child of a non-custodial parent when a court order for medical support exists, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who:

1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and
2. Is temporarily located outside the Eligible Participant's Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

**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:

1. That is provided for an Injury or a Sickness caused by the sudden, unexpected onset of a medical condition with acute symptoms of sufficient severity and pain to require immediate medical care; and
2. In the absence of which one could reasonably expect that one or more of the following would occur:
  - a. The Covered Person's health would be placed in serious jeopardy.
  - b. There would be serious impairment of the Covered Person's bodily functions.
  - c. There would be serious dysfunction of any of the Covered Person's bodily organs or parts.

**Experimental or 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. A covered drug will not be excluded from coverage on the grounds that the drug has not been approved by the Federal Food and Drug Administration for the particular indication if any of the following conditions are met: (1) the drug is recognized for treatment of the indication in at least one standard reference compendium; or (2) the drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.

**Home Country** means the Covered 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.

**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 Policy. 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 who is a resident patient of a Hospital, using and being charged for 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** means medical and dental service, treatment or supplies which are:

1. Recommended by the attending Physician;
2. Consistent with generally accepted medical practice for the Injury or Sickness, as determined by the Insurer;
3. Generally considered by Physicians in the United States of America or as determined by HTH as prevailing in the geographic locality where and at the time the service or supply is rendered to be appropriate for the Injury or Sickness; and
4. Accepted as safe, effective and reliable by a medical specialty or board recognized by the American Board of Medical Specialties or as determined by HTH as prevailing in the geographic locality where and at the time the service or supply is rendered.

A medical or dental treatment will not be deemed Medically Necessary if the Insurer determines that any service, supply or treatment used or provided in connection with the Injury or Sickness is Experimental or Investigational in nature. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary or covered by the Policy. If services do not meet the criteria above or are not consistent with professionally recognized standards of care with respect to quality, frequency or duration, such services will not be deemed Medically Necessary.

**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 Policy.

**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 Policy and which has been accepted by the Insurer for coverage under the Policy.

**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.

**Policy 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 Policy starts. It ends on the date the Covered Person's insurance under the Policy ends.

**Preferred Provider** means a Hospital, Physician, or other health care provider who has agreed to participate in the PPO.

**Preferred Provider Organization (PPO)** means the network(s) of Preferred Providers stated on the Insured 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 6 months 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 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.

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

**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 HTH 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 12:00:01am at the Covered Person's location.

## SECTION 10 EXTENSION OF BENEFITS

If the Insurer terminates the Policy, coverage will be extended for a Covered Person who:

1. Is Totally Disabled on the date coverage ends.

Coverage under this provision is provided only for Covered Medical Expenses with respect to:

1. A Totally Disabled Covered Person, for the condition causing the Total Disability

Coverage so extended will end on the first of the following to occur:

1. The last day of the 12<sup>th</sup> month following termination of the Policy; or
2. The date the Total Disability ends.

Except as stated above, coverage is not provided for any expense incurred after the date the Policy terminates.

This coverage extension will not apply to termination initiated by any Covered Person, Participating Organization or Institution or the Policyholder.

## SECTION 11 COORDINATION OF BENEFITS (COB)

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

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

The term "plan" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "plan" also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid. This provision may not be applied to claims less than \$250, but if additional liability is incurred to raise the small claim above \$250, the entire liability may be included in the coordination of benefits computations.

**Effect on Benefits.** Plans use COB to decide which plan should pay first for a covered expense. If this primary plan's payment is less than the charge for the allowable expense, then the second-paying (secondary) plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
  - a. First, benefits of a plan covering persons as an employee, member, or subscriber.
  - b. Second, benefits of a plan of an active worker covering persons as a dependent.
  - c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
  - a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
  - b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

- c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
  - d. When the parents are separated or divorced and the parent with custody has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
  - e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
  - f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits.
  5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
    - a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
    - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
  6. When rules 2 through 5 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

**Facility of Payment.** If another plan makes a benefit payment that should have been made by the Insurer, the Insurer has the right to pay the other plan any amount the Insurer deems necessary to satisfy the Insurer's obligation under these COB rules.

**Right of Recovery.** If the amount of the Insurer's benefit payment is more than the amount needed to satisfy the Insurer's obligation under these COB rules, the Insurer has the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

**Right to Receive and Release Necessary Information.** In order to carry out these COB rules:

1. The Insurer has the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as the Insurer deems necessary; and
2. Any person claiming benefits under this plan must give the Insurer any information necessary to carry out this provision.

## 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 Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.

**Enrollment for Coverage:** An Eligible Participant will be eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Policyholder, 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 Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date shown on the Insurance Identification Card.
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 HTH.

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 Policy 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. 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.

**When an Eligible Dependent's Coverage Starts:** An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date of the Eligible Participant's insurance;
4. The effective date shown on the insurance identification card;
5. The date the eligibility requirements in this section are met; or
6. The date the completed enrollment form, if any, and premium are received by the Insurer.

Thereafter, the insurance is effective 24 hours a day, worldwide. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

**When an Eligible Dependent's Coverage Ends.** An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates; or
2. The Participating Organization's or Institution's Termination Date;
3. The date the Eligible Participant is no longer covered under the Policy;
4. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;
5. 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country;
6. The date the Covered Person requests cancellation of coverage (the request must be in writing);
7. The premium due date for which the required premium has not been paid, or
8. The date on which the dependent ceases to meet the eligibility requirements.

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

**SECTION 13  
COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN**

**Coverage of Newborn Infants:** A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits. "Expenses for Routine nursery care" of a newborn infant of a covered Pregnancy are covered up to the limits, if any, shown in the Schedule of Benefits.

**Coverage of Adopted Children:** An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of the placement for adoption or the final decree of adoption, whichever occurs first, provided the Eligible Participant's coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement.

Newborn and adopted children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.

**Expenses for routine nursery care** means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.

In order to continue the coverage of a newborn child beyond the 31<sup>st</sup> day following his/her date of birth or of an adopted child beyond the 31<sup>st</sup> day following his/her placement:

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to HTH within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 31 days from the date of birth or placement.

**SECTION 14  
PREMIUM for Late/Open Enrollment**

**Payment:** Coverage is provided in return for payment of the required premium. Premiums may be paid monthly, quarterly, semi-annually, annually, or for a specified term, as arranged with HTH. Coverage will terminate if the required premium is not paid to the Insurer. Premium is charged from the date insurance for each Covered 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.

**Renewing Coverage:** Coverage for all Covered Persons shall be continuous if the acceptable renewal form and premium are received by the Insurer prior to the expiration of coverage. Premiums will be based upon the attained age of the Covered Person at the time of renewal. Any Covered Person whose coverage under the Policy lapses may re-enroll and shall be subject to all Policy exclusions as of any subsequent effective date.

**Grace Period:** There is a 31 day grace period after the premium due date in which to pay the required premium. The Policy and affected coverage will stay in force during the grace period. The grace period does not apply to payment of the first premium or the last premium when the Covered Person requests to terminate coverage in writing. The Covered Person is liable for all premiums unpaid, including any part or entire premium due through the grace period.

**SECTION 15  
CLAIM PROVISIONS**

**Notice of Claim:** Written notice of any claim under the Policy must be given to the Insurer or to the HTH within 30 days after the claim, 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 10 working days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy 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 HTH within 90 days after the date of loss. However, in case of claim for loss for which the Policy 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 are 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:** Within 15 working days after receipt of written proof of loss, the Insurer will pay benefits provided in the Policy or send to the Covered Person a notice stating the reasons for failing to pay the claim, either in whole or in part, and give the Covered Person a written itemization of any documents or other information needed to process the claim or any portions which are not being paid. When the Insurer has received all listed documents or other information needed to process the claim, the Insurer shall process the claim within 15 working days and either pay the claim or send a notice to the Covered Person denying the claim, in whole or in part, and give the Covered Person the reasons for the denial.

The Insurer shall pay to the Covered Person or other person claiming payments under the Policy interest equal to 18% per annum on the benefits due under the Policy for failure to comply with these provisions.

**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 Policy 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.

**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 Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

## SECTION 16 GENERAL PROVISIONS

**Entire Contract:** The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder (Participating Organization or Institution), copies of which are attached to and made a part of the Policy. All statements contained in the application 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 Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

**Incontestability:** The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Policy 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 Policy 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 Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. 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 Policy 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 HTH. 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 Policy.

**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 HTH. The beneficiary's consent is not required for this or any other change in the Policy 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 Policy does not satisfy any requirement for Workers' Compensation.

**Right of Reimbursement:** If a covered person has a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or injury for which benefits are paid under this program, the Insurer shall have a right of recovery. The Insurer's right of recovery shall be limited to the amount of any benefits paid for covered medical expenses under this program, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. The Insurer's right of recovery shall include compromise settlements. You or your attorney must inform the Insurer of any legal action or settlement discussion, ten days prior to settlement or trial. The Insurer will then notify you of the amount of your legal expenses it will pay.

**Right of Recovery:** Whenever the Insurer has made payments with respect to benefits payable under the Policy 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 Policy to the extent of the overpayment.

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

1. **Disclosure of Covered Person's Rights:** Each Covered Person has the right to:
2. Receive medically appropriate care in a timely and convenient manner;
3. Participate in decision making regarding treatment, care and services;
4. Receive information about the plan, services and providers;
5. Voice complaints or request appeals and have them addressed in a timely manner; and
6. Have a family member or designated person facilitate any care when the Covered Person is unable to do so.
7. **Covered Person's Responsibilities:** It is the Covered Person's responsibility to:
8. Provide necessary information to facilitate effective medical care;
9. Cooperate with health care providers by keeping appointments and following recommended treatment; and
10. Follow the Policy's rules and regulations.

**Grievance Procedures:** A Covered Person may file a grievance to the Insurer or HTH. A grievance submitted will be forwarded for review by a panel of 3 Board Certified physicians, none of whom were involved in the original claim decision. The Covered Person will be provided with prompt written notice (within 60 days) of the outcome of the grievance. If the outcome is favorable to the Covered Person, the claim will be processed according to the recommendations of the panel and the Policy's terms and provisions. If the outcome of the grievance is unfavorable to the Covered Person, the Covered Person will be provided with specific findings related to the claim and the Policy's terms and provisions relied upon in making the determination.

**Summary of Grievances Filed:** A Covered Person may request a summary of the number, nature and outcome results of grievances filed in the previous 3 years prior to the request. Copies of the summary will be made available at reasonable costs.

---

In accordance with state insurance law, this certificate is composed of the following forms on file with the State Insurance Department.

|  |           |       |
|--|-----------|-------|
| Certificate                                      | BCR 103   | 03/03 |
| Schedule of Benefits – Eligibility Classes       | BCR 130   | 03/03 |
| Schedule of Benefits – Table 1                   | BCR 131   | 03/03 |
| Schedule of Benefits – Table 2                   | BCR 132   | 03/03 |
| Schedule of Benefits – Table 3                   | BCR 133   | 03/03 |
| Description of Coverages – Medical Expenses      | BCR 360   | 03/03 |
| Accidental Death and Dismemberment Benefit       | BCR 210   | 03/03 |
| Repatriation of Remains Benefit                  | BCR 140   | 03/03 |
| Medical Evacuation Benefit                       | BCR 141   | 03/03 |
| Bedside Visit Benefit                            | BCR 142   | 03/03 |
| Pre-Existing Condition Limitation                | BCR 361   | 03/03 |
| General Policy Exclusions                        | BCR 143   | 03/03 |
| Definitions                                      | BCR 110   | 03/03 |
| Extension of Benefits                            | BCR 144   | 03/03 |
| Coordination of Benefits (COB)                   | BCR 146   | 03/03 |
| Eligibility Requirements and Period of Coverage  | BCR 120   | 03/03 |
| Coverage of Newborn Infants and Adopted Children | BCR 147   | 03/03 |
| Premium  | BCR 170   | 03/03 |
| Claim Provisions                                 | BCR 171   | 03/03 |
| General Provisions                               | BCR 172.1 | 10/03 |

Administered by:  
Worldwide Insurance Services, Inc.  
One Radnor Corporate Center, Suite 100  
Radnor, PA 19087  
Customer Service: 866.510.8780