

SERFF Tracking Number: DLAL-126475792 State: Arkansas
 Filing Company: Delaware American Life Insurance Company State Tracking Number: 45230
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Expat Policy Filing
 Project Name/Number: Expat Policy Filing/

Filing at a Glance

Company: Delaware American Life Insurance Company

Product Name: Expat Policy Filing

SERFF Tr Num: DLAL-126475792 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 45230

Sub-TOI: H21.000 Health - Other

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Joanne Spruill, Julie
Sheldon

Disposition Date: 07/06/2010

Date Submitted: 03/23/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Expat Policy Filing

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 07/06/2010

Explanation for Other Group Market Type:

State Status Changed: 07/06/2010

Deemer Date:

Created By: Joanne Spruill

Submitted By: Joanne Spruill

Corresponding Filing Tracking Number:

PPACA: Pre-PPACA Submission

Filing Description:

Attached are the forms for your review and approval. These forms are new, and are not intended to replace any other forms previously filed with your Department.

The intent of this filing is to provide Employee Benefit plans for employers located in the United States (US) covering employees primarily residing and working outside the US and outside their country of permanent residence.

Group policies will be delivered to the business or registered offices of employer located in Delaware or through a

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Delaware Trust. Certificates will be provided to the employer for delivery mainly to employees who are not residents in the US.

These benefit plans can be a combination of either Group Term Life, AD&D, Medical, Dental, Vision and Long Term Disability coverage.

Company and Contact

Filing Contact Information

Joanne Spruill, Paralegal II joanne.spruill@alico.com
 P.O. Box 1449 302-594-2640 [Phone]
 600 King St 302-830-4448 [FAX]
 Wilmington, DE 19899

Filing Company Information

Delaware American Life Insurance Company	CoCode: 62634	State of Domicile: Delaware
P.O. Box 1449	Group Code:	Company Type:
600 N King St	Group Name:	State ID Number:
Wilmington, DE 19899	FEIN Number: 51-0104167	
(302) 594-2640 ext. [Phone]		

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/06/2010	07/06/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	04/01/2010	04/01/2010	Julie Sheldon	06/15/2010	06/15/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Statement of Variability	Note To Reviewer	Julie Sheldon	06/15/2010	06/15/2010
Objection letter of 4/1/10	Note To Filer	Rosalind Minor	05/21/2010	05/21/2010
Filing Fee	Note To Reviewer	Julie Sheldon	04/07/2010	04/07/2010
Filing fee	Note To Filer	Rosalind Minor	03/29/2010	03/29/2010
Filing Fees	Note To Reviewer	Julie Sheldon	03/26/2010	03/26/2010

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Disposition

Disposition Date: 07/06/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Delam Expat Policy	Approved-Closed	Yes
Form	Group Certificate Rider	Approved-Closed	Yes
Form	Group Insurance Application	Approved-Closed	Yes
Form	Expat Certificate Life/ADD	Approved-Closed	Yes
Form	Expat Certificate LTD	Approved-Closed	Yes
Form (revised)	Expat Certificate MDV	Approved-Closed	Yes
Form	Expat Certificate MDV	Replaced	Yes
Form	Group Policy Amendment	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/01/2010

Submitted Date 04/01/2010

Respond By Date

Dear Joanne Spruill,

This will acknowledge receipt of the captioned filing.

Objection 1

- Expat Certificate MDV, G10070H - Delam 6/09 (Form)

Comment:

Under the Schedule of Benefits, some benefits payable a Network Provider and Non-Network Provider appear to not be in compliance with our Bulletin 9-85. This bulletin states under item 2 that the difference in benefits levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 06/15/2010
 Submitted Date 06/15/2010

Dear Rosalind Minor,

Comments:

Following is in response to your objection dated April 1, 2010.

Response 1

Comments: We have revised the forms to show variability which should comply with AR requirements. A statement of variability is attached. Please withdrawal the removed policy and certificate ammendments from review.

Thank you.

Related Objection 1

Applies To:

- Expat Certificate MDV, G10070H - Delam 6/09 (Form)

Comment:

Under the Schedule of Benefits, some benefits payable a Network Provider and Non-Network Provider appear to not be in compliance with our Bulletin 9-85. This bulletin states under item 2 that the difference in benefits levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Expat Certificate MDV	G10070H		Certificate	Initial		54.700	Delam

<i>SERFF Tracking Number:</i>	<i>DLAL-126475792</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Delaware American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45230</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Expat Policy Filing</i>		
<i>Project Name/Number:</i>	<i>Expat Policy Filing/ - Delam 6/09</i>		<i>Expat-cert M D V (Variable) 1.pdf</i>

Previous Version

<i>Expat Certificate MDV</i>	<i>G10070H</i>	<i>Certificate</i>	<i>Initial</i>	<i>54.700</i>	<i>Delam Expat-cert M D V.pdf</i>
	<i>- Delam 6/09</i>				

No Rate/Rule Schedule items changed.

Sincerely,
Joanne Spruill, Julie Sheldon

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Note To Reviewer

Created By:

Julie Sheldon on 06/15/2010 01:39 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/06/2010 12:38 PM

Subject:

Statement of Variability

Comments:

Attached is the statement of variability.

STATEMENT OF VARIABILITY

Information that may be included on based on case specifics is contained in brackets []. Illustrative information including class identifiers, benefit amounts, age, ranges, time durations, references to optional benefits and provisions customized to fit the policyholder's benefit plan using { }. In no event will the information contain in these bracketed areas be less favored to the Insured than the minimum standards set forth in your law.

General Comments

Please note the following:

This policy form is designed to be issued (a) directly to an employer or other eligible group or (b) to a trust which multiple employers or other eligible entities may subscribe.

References to the Person(s) Insured

The terms "Employee", "Member", "Covered Person", etc., may be used as applicable to reflect Policy/Certificate issuance to employer/employee groups or other eligible groups under the law of your state. A term other than "Employee" or "Member" may be used if requested by a policyholder for consistency with other policies or with personnel practices. Modifications may also be made to reflect coverage provided to a specific Covered Class of insureds.

Gender Neutrality

The male pronoun is used throughout the form and, is defined to include the female pronoun wherever referenced. These references may be changed to gender neutral terms upon issuance of the Policy/Certificate.

Combined Coverages

The Policy/Certificate pages may reflect the application of certain provisions to distinct coverages. For example, the description of classes may vary depending on the nature of the group, the coverages provided and the plan offered by the Policyholder. Different provisions may apply on coverage distinct basis.

Listed below is a description of variable text along with corresponding explanation of the scope of variability.

G10070 – Delam 6/09 – Delam Expat Policy

1. Will vary between on company of issuance or Delaware Trust
2. May be included or excluded
3. May vary based on whether policy is direct or trust issued
4. Will be included if policy is issued through a trust
5. Will vary based on assigned policy issuance number
6. Will vary based on date of policy issuance
7. Will vary based on date of policy issuance and agreed renewal date
8. Will be included if policy is issued through a trust
9. Will be included if policy is issued through a trust
10. Will be included unless premium amounts are something other than U.S. Dollars

11. Will be between 60 and 270 days
12. Will vary but will always be less than state mandates on small employer group coverage
13. Will vary between 50 and 75 percent
14. Will vary between 31 and 90 days
15. Will vary between 60 and 270 days
16. Will vary between 60 and 270 days
17. Will vary between 60 and 270 days
18. Will vary between 60 and 270 days
19. Will vary between 15 percent and 35 percent

G10070APP – Delam 6/09 – Group Insurance Application

1. Will vary based on name of company or name of trust if applicable
2. Will vary based on the address of the applicant or address of the trust
3. Will vary based on the number of employees covered for this type of coverage
4. Will vary based on the number of dependents and employees covered under this type of coverage
5. Will vary based on the number of employees covered for this of coverage
6. Will vary based on the number of employees covered for this of coverage
7. Will vary based on the number of employees covered for this of coverage
8. Will vary based on the number of employees covered for this of coverage
9. Will vary based on the number of employees covered for this of coverage
10. Will vary based on the date the policy is issued

G10070L– Delam 6/09 – Expat Certificate, Life, and ADD

1. Will vary based on name of company issued or name of trust
2. Will vary based on date of policy issuance
3. Will vary based on the assigned group policy number at issuance
4. Will vary based on the company name
5. Will be included if accident coverage is added
6. Will vary between participating employer (if trust issued) and policyholder
7. May be included or excluded based on policyholder request
8. May be included or excluded based on policyholder request
9. May be included or excluded based on policyholder request

10. May be included or excluded based on policyholder request
11. May be included or excluded based on policyholder request
12. Will be included if dependents are covered
13. May be included or excluded based on policyholder request
14. May be included or excluded based on policyholder request
15. May be included or excluded based on policyholder request
16. May be included or excluded based on policyholder request
17. May be included or excluded based on policyholder request
18. May be included or excluded based on policyholder request
19. May be included or excluded based on policyholder request
20. Will be included if life insurance coverage is elected
21. Will be included if AD&D coverage is elected
22. May include any or all employee types – U.S., Expatriate, Third Country National
23. May vary between 25 and 40 hours per week
24. May vary accordingly to policyholder intent but will always conform to state law
25. Will be included if dependent coverage is elected
26. Will be included if dependent coverage is elected
27. Will vary between 90 and 365 days
28. May be included or excluded
29. May vary between none and 60 days
30. May be included or excluded
31. May vary between none and 60 days
32. May be included or excluded
33. May vary between none and 60 days
34. May be included or excluded
35. May read open or annual
36. May vary based on the effective date and type of enrollment
37. May vary based on the type of enrollment
38. May be included or excluded
39. May be included or excluded
40. May vary from one to five times annual salary and a maximum between \$10,000 and \$1,500,000

41. May be included or excluded
42. May vary from one to five times annual salary and a maximum between \$10,000 and \$1,500,000
43. May be included or excluded
44. May vary between one to three times base salary and 12, 24, or 36 monthly installments
45. May be included or excluded
46. May vary between \$1,000,000 and \$1,500,000
47. May be included or excluded
48. May vary between \$5,000 and \$250,000
49. May vary between 7 and 21 days or as mandated by state law
50. May vary between \$500 and \$50,000
51. May be included as dependent coverage is elected
52. May vary to read Basic, Voluntary, Supplemental and/or Survival income based on selected criteria
53. May be included or excluded
54. May be included if dependent coverage is chosen
55. May vary between \$100,000 and \$1,000,000
56. May be included or excluded
57. May be included or excluded
58. May be between \$25,000 and \$50,000
59. May be included or excluded
60. May be included or excluded
61. May be between one and five times
62. May vary between \$10,000 and \$1,500,000
63. May be included or excluded
64. May be between one and three times
65. May vary between \$100,000 and \$1,000,000
66. May be included or excluded
67. May be included or excluded
68. May be included if Accident coverage is elected
69. May be included if Accident coverage is elected
70. May vary between 35 percent and 50 percent
71. May vary between age 65 or older according to ADEA requirements

- 72. May vary between 15 percent and 25 percent
- 73. May vary between age 70 and older
- 74. May be included or excluded
- 75. May be included if Accident coverage is elected
- 76. May be included if Accident coverage is elected
- 77. May be included or excluded
- 78. May be included or excluded
- 79. May be included or excluded
- 80. May be included or excluded
- 81. May be included or excluded
- 82. May be included or excluded
- 83. May be included or excluded
- 84. May be included or excluded
- 85. May be included or excluded
- 86. May be included or excluded
- 87. May be included or excluded
- 88. May be included or excluded
- 89. May be included or excluded
- 90. May be included or excluded
- 91. May be included or excluded
- 92. May vary based on state age of majority between 19 and 26
- 93. May vary based on state or federal law
- 94. May be included or excluded
- 95. May be included or excluded
- 96. May be included or excluded
- 97. May be included or excluded
- 98. May be included or excluded
- 99. May be included or excluded
- 100. May be included or excluded
- 101. May be included or excluded
- 102. May be included or excluded

- 103. May be included or excluded
- 104. May be included or excluded if Dependent coverage is added
- 105. May be included or excluded
- 106. May be included or excluded
- 107. May be included or excluded
- 108. May be included or excluded
- 109. May vary between three and twelve months based on state
- 110. May be included or excluded
- 111. May be included or excluded
- 112. May be included or excluded
- 113. May be included or excluded
- 114. May be included or excluded based on addition of seatbelt benefit
- 115. May be included or excluded
- 116. May be included or excluded
- 117. May be included or excluded
- 118. May be included or excluded
- 119. May be included or excluded based on addition of dependent coverage
- 120. May be included or excluded
- 121. May be included or excluded
- 122. May be included or excluded
- 123. May be included or excluded
- 124. May be included or excluded
- 125. May be included or excluded
- 126. Will vary between 1 and 3
- 127. May be included or excluded
- 128. Will vary between 1 and 3
- 129. May be included or excluded
- 130. May be included or excluded
- 131. May be included or excluded
- 132. May be included or excluded
- 133. May be included or excluded

- 134. May be included or excluded
- 135. May vary based on coverage elected
- 136. May be included or excluded
- 137. May be included or excluded
- 138. May be included or excluded
- 139. May vary between 6 and 18 months
- 140. May be included or excluded
- 141. May vary between 60 days and 365 days
- 142. May be included or excluded
- 143. May vary between 60 days and 365 days
- 144. May vary between 60 days and 365 days
- 145. May be included or excluded
- 146. May be included or excluded
- 147. May vary between 65 and 75 or normal retirement age
- 148. May be included or excluded
- 149. May vary between 55 and 75 or normal retirement age
- 150. May vary between age 70 and 85
- 151. May be included or excluded
- 152. May be included or excluded
- 153. May vary between 55 and 75 or normal retirement age
- 154. May vary between 6 to 12 months
- 155. May vary between 60 to 72 months
- 156. May be included or excluded
- 157. May vary based on home office location
- 158. May vary between 5 to 7 years
- 159. May vary between 5 to 7 years
- 160. May vary between \$2,000 and \$5,000
- 161. May be included or excluded if Conversion coverage is elected
- 162. May vary between 60 and 80 percent
- 163. May vary between \$25,000 and \$500,000
- 164. May vary between 12 and 24 months

- 165. May vary between \$15,000 and \$20,000
- 166. Not variable
- 167. Not variable
- 168. Not variable
- 169. May be included or excluded
- 170. May be included or excluded
- 171. May be included or excluded
- 172. May be included or excluded based on coverage chosen
- 173. May be included or excluded
- 174. May be included or excluded
- 175. May vary based on state mandate
- 176. May be included or excluded
- 177. May be included or excluded
- 178. May be included or excluded
- 179. May be included or excluded
- 180. May vary between 12 and 24
- 181. May be included or excluded
- 182. May be included or excluded
- 183. May vary between 12 and 24
- 184. May be included or excluded
- 185. May be included or excluded
- 186. May be included or excluded
- 187. May be included or excluded
- 188. May be included or excluded
- 189. May be included or excluded
- 190. May be included or excluded
- 191. May vary between 120 days and 365 days
- 192. May be included or excluded
- 193. May be included or excluded
- 194. May be included or excluded
- 195. May be included or excluded

- 196. May be included or excluded
- 197. May be included or excluded
- 198. May vary between \$10,000 and \$100,000
- 199. May be included or excluded
- 200. May be included or excluded
- 201. May be included or excluded
- 201. May be included or excluded
- 202. May be included or excluded
- 203. May be included or excluded
- 204. May be included or excluded
- 205. May be included or excluded
- 206. May be included or excluded
- 207. May be included or excluded
- 208. May be included or excluded
- 209. May be included or excluded
- 210. May be included or excluded
- 211. May vary between 15 days and 50 days based on state mandate
- 212. May be based on home office address
- 213. May vary between 15 and 30 days based on state mandate
- 214. May vary between 90 and 120 days based on state mandate
- 215. May vary between \$5,000 and \$10,000
- 216. May vary between 500 and 1,000
- 217. May vary between 60 and 90
- 218. May vary between 2 and 3
- 219. May be included or excluded
- 220. May be included or excluded
- 221. May vary between 30 days and 180 days
- 222. May vary between 30 days and 180 days
- 223. Will vary based on company name
- 224. Will vary based on plan name
- 225. Will vary based on issued plan number

- 226. Will vary to read employer's address
- 227. Will vary to read employer's identification number
- 228. May vary to read any or all listed based on coverage chosen
- 229. May vary to read any or all listed based on coverage chosen
- 230. May vary to read any or all listed based on coverage chosen
- 231. Will vary based on company name
- 232. May vary to read any or all listed based on coverage chosen
- 233. Will vary based on agent provided
- 234. Will vary based on source of contributions
- 235. Will vary to read Plan or Calendar
- 236. Will vary based on plan or calendar year chosen

G10070D– Delam 6/09 – Expat Certificate LTD

- 1. Will vary based on the date of policy issuance
- 2. Will vary based on assigned policy number at policy issuance
- 3. Will vary based on name of company or trust at policy issuance
- 4. May be included or excluded based on policyholder request
- 5. May be included or excluded based on policyholder request
- 6. May be included or excluded based on policyholder request
- 7. May be included or excluded based on policyholder request
- 8. May be included or excluded based on policyholder request
- 9. May be included or excluded based on policyholder request
- 10. May be included or excluded based on policyholder request
- 11. May be included or excluded based on policyholder request
- 12. May be included or excluded based on policyholder request
- 13. May be included or excluded based on policyholder request
- 14. May be included or excluded based on policyholder request
- 15. May be included or excluded based on policyholder request
- 16. May be included or excluded based on policyholder request
- 17. May be included or excluded based on policyholder request
- 18. May include any or all of Employee types – U.S., Expatriate, Third Country National

19. May vary between 25 and 40 hours per week
20. May be included or excluded
21. May be included if dependent coverage is included
22. May be included at the policyholder's request
23. May be included if dependent coverage is included
24. May vary between 60 days and 180 days
25. May be included or excluded
26. May vary between none and 180 days
27. May be included or excluded if LTD coverage is requested
28. May read Open or Annual based on policyholder request
29. May vary based on policyholder request
30. May be included or excluded based on policyholder request
31. May vary based on policyholder request
32. May be included or excluded
33. May vary between age 65 to age 80, or read "normal retirement age"
34. May vary between 50 and 66 ^{2/3} per percent
35. May vary between \$1,500 and \$15,000
36. May vary between 0 and 10 percent
37. May be included or excluded at policyholder's request
38. May vary between 0 and 10 percent
39. May be included or excluded at policyholder's request
40. May vary between 0 and 10 percent
41. May be included or excluded at policyholder's request
42. May vary between 30 and 365 days
43. May vary between 3/12 months, 5 days, 6/12/24 months based on state requirements
44. May vary between "to age 65", "normal retirement age", or "reducing benefit duration"
45. May be included or excluded
46. May vary between totally and partially
47. May vary based on policyholder request
48. May be included or excluded
49. May vary between 1 and 8 percent

50. May be included or excluded based on policyholder request
51. May be included or excluded based on the election of AD&D coverage
52. May be included or excluded
53. May vary between totally and partially
54. May be included if "similar occupation" is elected by the policyholder
55. May vary between totally and partially
56. May be included if "any occupation" coverage is elected by the policyholder
57. May be included or excluded
58. May be included or excluded
59. May be included or excluded
60. May be included or excluded
61. May be included or excluded based on option chosen
62. May be included or excluded based on option chosen
63. May be included or excluded based on option chosen
64. May be included or excluded based on option chosen
65. May be included or excluded based on option chosen
66. May be included or excluded based on option chosen
67. May be included or excluded based on option chosen
68. Will vary between 26 and under
69. Will vary between 3, 5, 7 and 14 days
70. May be included or excluded
71. May be included or excluded
72. May be included or excluded
73. May be included or excluded
74. May be included or excluded
75. May be included or excluded
76. May be included or excluded if dependent coverage is added
77. May be included or excluded
78. May be included or excluded
79. May be included or excluded
80. May be included or excluded based on option chosen

81. May be included if policy is trust issued
82. May vary based on state definition
83. May vary based on state definition
84. May vary based on state definition
85. May vary to read totally or partially
86. May be included or excluded
87. May vary between 10 percent and 20 percent
88. Correlates with #87 – may vary between 90 percent and 80 percent
89. Not variable
90. May be included or excluded
91. May be included or excluded
92. May be included or excluded
93. May be included or excluded
94. May be included or excluded based on whether coverage is chosen
95. May be included or excluded
96. May be included or excluded
97. May be included or excluded
98. May be included or excluded
99. May be included or excluded
100. May be included or excluded
101. May be included or excluded
102. May be included or excluded
103. May be included or excluded
104. May be included or excluded
105. Not variable
106. May be included or excluded
107. Not variable
108. May be included or excluded
109. May vary between 30 and 180 days
110. May be included or excluded
111. May be between 30 and 180 days

- 112. May be included or excluded
- 113. May be included or excluded based on plan chosen
- 114. May be included or excluded based on plan chosen
- 115. May be included or excluded based on plan chosen
- 116. May be included if dependent coverage is chosen
- 117. May be included if dependent coverage is chosen
- 118. May be included if dependent coverage is chosen
- 119. May be included or excluded
- 120. May be included or excluded
- 121. Will vary between totally and partially
- 122. May be included or excluded based on plan chosen
- 123. Will vary between totally and partially
- 124. May be included or excluded based on plan chosen
- 125. Will be between 10 percent and 20 percent
- 126. Not variable
- 127. May be included or excluded
- 128. May be included or excluded
- 129. Not variable
- 130. May be included or excluded
- 131. May be included or excluded
- 132. May be included or excluded
- 133. May vary between 80 percent and 90 percent
- 134. Not variable
- 135. May be included or excluded
- 136. May be included or excluded
- 137. May vary to read date or age
- 138. May be included or excluded
- 139. May vary between 3 and 12 months
- 140. May vary between 3 and 12 months
- 141. May vary between 30 and 180 days
- 142. May vary between 3 and 6 months

- 143. May be included or excluded based on plan chosen
- 144. May be included or excluded based on plan chosen
- 145. May vary to read either partially or residually
- 146. Not variable
- 147. May be included or excluded
- 148. May be included or excluded
- 149. May be included or excluded
- 150. Not variable
- 151. May be included or excluded
- 152. May be included or excluded
- 153. May be included or excluded
- 154. Not variable
- 155. May be included or excluded
- 156. May be included or excluded
- 157. May be included or excluded
- 158. May vary between 50 percent and 70 percent
- 159. Not variable
- 160. May be included or excluded
- 161. May be included or excluded
- 162. May be included or excluded
- 163. May be included or excluded
- 164. May be included or excluded
- 165. May be included or excluded
- 166. May be included or excluded
- 167. May be included or excluded
- 168. May be included or excluded
- 169. May be included or excluded
- 170. May be included or excluded
- 171. May be included or excluded
- 172. May be included or excluded
- 173. May be included or excluded

- 174. May be included or excluded
- 175. May be included or excluded
- 176. May be included or excluded
- 177. May be included or excluded
- 178. May be included or excluded
- 179. May be included or excluded
- 180. May be included or excluded
- 181. May be included or excluded
- 182. May be included or excluded
- 183. May be included or excluded
- 184. May vary between 6 and 18 months
- 185. May vary between 6 and 18 months
- 186. May be included or excluded
- 187. May be included or excluded
- 188. May be included or excluded
- 189. May be included or excluded
- 190. May be included or excluded
- 191. May be included or excluded
- 192. May vary between 15 and 45 days based on state mandate
- 193. May vary based on state mandate
- 194. May be included or excluded
- 195. May vary between 30 and 90 days based on state mandate
- 196. May vary between 2 and 5 years based on state mandate

G10070H – Delam 6/09 – Expat Certificate MDV

- 1. Will vary based on employer name
- 2. Will vary based on effective date of policy
- 3. May be included or excluded
- 4. Will vary based on policy number assigned at issuance
- 5. Will vary based on employer name
- 6. May include any or all listed based on coverage chosen
- 7. May be included or excluded

8. May be included or excluded
9. May be included or excluded
10. May be included or excluded
11. May be included or excluded
12. May be included or excluded
13. May be included or excluded
14. May be included or excluded
15. May be included or excluded
16. May be included or excluded
17. May be included or excluded
18. May be included or excluded
19. May be included or excluded
20. May be included or excluded
21. May be included or excluded
22. May be included or excluded
23. May be included or excluded
24. May be included or excluded
25. May vary between any and all listed
26. May vary between 20 and 35 hour per week
27. May vary based on definition chosen but not to exceed state mandates
28. May be included or excluded
29. May be included or excluded
30. May vary between 90 and 365 days
31. May be included or excluded
32. May vary between none and 3 months
33. May be included or excluded
34. May vary between none and 3 months
35. May be included or excluded
36. May vary between none and 3 months
37. May be included or excluded
38. May vary between none and 3 months

39. May be included or excluded
40. May vary based on the type of enrollment chosen and effective date
41. May vary based on date of open enrollment period
42. May be included or excluded
43. May be included or excluded
44. May be included or excluded
45. May vary based on countries where the network is available
46. May be included or excluded
47. May be included or excluded
48. May be included or excluded
49. May be included or excluded
50. May be included or excluded
51. May vary between \$0 and \$5,000
52. May vary between \$0 and \$10,000
53. May vary between \$0 and \$5,000
54. May vary between \$0 and \$10,000
55. May be included or excluded
56. May be included or excluded
57. May be included or excluded
58. May be included or excluded
59. May be included or excluded
60. May vary up to 3 times the amount listed for the Individual deductible (see #51)
61. May vary up to 3 times the amount listed for the Individual deductible (see #52)
62. May vary up to 3 times the amount listed for the Individual deductible (see #53)
63. May vary up to 3 times the amount listed for the Individual deductible (see #54)
64. May be included or excluded
65. May be included or excluded
66. May vary between \$0 and \$500
67. May be included or excluded
68. May be included or excluded
69. May vary between \$0 and \$1,000

- 70. May be included or excluded
- 71. May be included or excluded
- 72. May be included or excluded
- 73. May be included or excluded
- 74. May be included or excluded
- 75. May be included or excluded
- 76. May be included or excluded
- 77. May be included or excluded
- 78. May be included or excluded
- 79. May be included or excluded
- 80. May vary between \$0 and \$100
- 81. May vary to read either deductible or coinsurance
- 82. May be included or excluded
- 83. May be included or excluded
- 84. May vary between \$0 and \$100
- 85. May vary to read current language or deductible/coinsurance
- 86. May be included or excluded
- 87. May be included or excluded
- 88. May vary between \$0 and \$100
- 89. May vary to read either deductible or coinsurance
- 90. May be included or excluded
- 91. May be included or excluded
- 92. May vary between \$0 and \$250
- 93. May vary to read either deductible or coinsurance
- 94. May be included or excluded
- 95. May be included or excluded
- 96. May vary between \$0 and \$250
- 97. May vary to read either deductible or coinsurance
- 98. May be included or excluded
- 99. May be included or excluded
- 100. May vary between \$0 and \$100

- 101. May vary to read either deductible or coinsurance
- 102. May be included or excluded
- 103. May vary to read any or all listed based on coverages elected
- 104. May be included or excluded
- 105. May be included or excluded
- 106. May be included or excluded
- 107. May be included or excluded
- 108. May be included or excluded
- 109. May be included or excluded
- 110. May vary between \$0 and \$10,000
- 111. May vary up to 25 times in network
- 112. May vary between \$0 and \$10,000
- 113. May vary up to 25 times in network
- 114. May be included or excluded
- 115. May be included or excluded
- 116. May be included or excluded
- 117. May be included or excluded
- 118. May be included or excluded
- 119. May vary up to 3 times Individual out-of-pocket maximum (see #110)
- 120. May vary up to 3 times Individual out-of-pocket maximum (see #111)
- 121. May vary up to 3 times Individual out-of-pocket maximum (see #112)
- 122. May vary up to 3 times Individual out-of-pocket maximum (see #113)
- 123. May be included or excluded
- 124. May be included or excluded
- 125. May be included or excluded
- 126. May be included or excluded
- 127. May be included or excluded
- 128. May be included or excluded
- 129. May be included or excluded
- 130. May be included or excluded
- 131. May be included or excluded

- 132. May be included or excluded
- 133. May vary between 70 percent and 100 percent
- 134. May vary between 70 percent and 100 percent
- 135. May vary between 70 percent and 100 percent
- 136. May vary between 70 percent and 100 percent
- 137. May be included or excluded
- 138. May be included or excluded
- 139. May be included or excluded
- 140. May be included or excluded
- 141. May be included or excluded
- 142. May vary between 70 percent and 100 percent
- 143. May vary between 70 percent and 100 percent
- 144. May vary between 70 percent and 100 percent
- 145. May vary between 70 percent and 100 percent
- 146. May be included or excluded
- 147. May be included or excluded
- 148. May be included or excluded
- 149. May be included or excluded
- 150. May be included or excluded
- 151. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 152. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 153. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 154. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 155. May be included or excluded
- 156. May be included or excluded
- 157. May be included or excluded
- 158. May be included or excluded
- 159. May be included or excluded
- 160. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 161. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 162. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"

- 163. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 164. May be included or excluded
- 165. May be included or excluded
- 166. May be included or excluded
- 167. May be included or excluded
- 168. May be included or excluded
- 169. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 170. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 171. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 172. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 173. May be included or excluded
- 174. May be included or excluded
- 175. May be included or excluded
- 176. May be included or excluded
- 177. May be included or excluded
- 178. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 179. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 180. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 181. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 182. May be included or excluded
- 183. May be included or excluded
- 184. May be included or excluded
- 185. May be included or excluded
- 186. May be included or excluded
- 187. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 188. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 189. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 190. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 191. May be included or excluded
- 192. May be included or excluded
- 193. May be included or excluded

- 194. May be included or excluded
- 195. May be included or excluded
- 196. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 197. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 198. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 199. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 200. May be included or excluded
- 201. May be included or excluded
- 202. May be included or excluded
- 203. May be included or excluded
- 204. May be included or excluded
- 205. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 206. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 207. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 208. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 209. May be included or excluded
- 210. May be included or excluded
- 211. May be included or excluded
- 212. May be included or excluded
- 213. May be included or excluded
- 214. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 215. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 216. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 217. May vary between 70 and 100 percent and may vary between "deductible waived" or "subject to deductible"
- 218. May be included or excluded
- 219. May be included or excluded
- 220. May be included or excluded
- 221. May be included or excluded
- 222. May be included or excluded
- 223. May be between 70 percent and 100 percent
- 224. May be between 70 percent and 100 percent

- 225. May be included or excluded
- 226. May be included or excluded
- 227. May be included or excluded
- 228. May be included or excluded
- 229. May be included or excluded
- 230. May vary between 70 percent and 100 percent
- 231. May vary between 70 percent and 100 percent
- 232. May vary between 70 percent and 100 percent
- 233. May vary between 70 percent and 100 percent
- 234. May be included or excluded
- 235. May be included or excluded
- 236. May be included or excluded
- 237. May be included or excluded
- 238. May be included or excluded
- 239. May vary between 70 percent and 100 percent
- 240. May vary between 70 percent and 100 percent
- 241. May vary between 70 percent and 100 percent
- 242. May vary between 70 percent and 100 percent
- 243. May be included or excluded
- 244. May be included or excluded
- 245. May be included or excluded
- 246. May vary based on policy layout
- 247. May be included or excluded
- 248. May be included or excluded
- 249. May vary between 1 and 10 million dollars
- 250. May vary between \$25,000 and \$100,000
- 251. May be included or excluded
- 252. May vary between 5 and 15
- 253. May vary between 1 and 5
- 254. May vary between 5 and 17
- 255. May vary between \$400 and no maximum

- 256. May read "calendar" or "plan"
- 257. May read "all" or "each"
- 258. May be included or excluded
- 259. May be included or excluded
- 260. May be included or excluded
- 261. May vary between \$400 and no maximum
- 262. May read "calendar" or "plan"
- 263. May read "all" or "each"
- 264. May be included or excluded
- 265. May be included or excluded
- 266. May be included or excluded
- 267. May be included or excluded
- 268. May vary between \$25,000 and \$250,000
- 269. May be included or excluded
- 270. May vary between \$10,000 and no limit
- 271. May be included or excluded
- 272. May vary between 10 and 60
- 273. May read "calendar" or "plan"
- 274. May be included or excluded
- 275. May vary between \$2,500 and \$50,000
- 276. May vary between \$500 and \$50,000
- 277. May be included or excluded
- 278. May be included or excluded
- 279. May vary between \$2,500 and \$50,000
- 280. May be included or excluded
- 281. May vary between \$1,000 and no maximum
- 282. May read "calendar" or "plan"
- 283. May be included or excluded
- 284. May vary between 10 and 60
- 285. May read "calendar" or "plan"
- 286. May be included or excluded

- 287. May vary between 10 and 60
- 288. May read "calendar" or "plan"
- 289. May be included or excluded
- 290. May be included or excluded
- 291. May vary between 10 and 60
- 292. May read "calendar" or "plan"
- 293. May be included or excluded
- 294. May be included or excluded
- 295. May be included or excluded
- 296. May vary between 10 and 100
- 297. May read "calendar" or "plan"
- 298. May be included or excluded
- 299. May be included or excluded
- 300. May vary between \$200 and the plan limit
- 301. May vary between \$2,500 and the plan limit
- 302. May be included or excluded
- 303. May vary between none and five
- 304. May read "calendar" or "plan"
- 305. May be included or excluded
- 306. May be included or excluded
- 307. May vary between 40 and 240
- 308. May read "calendar" or "plan"
- 309. May be included or excluded
- 310. May be included or excluded
- 311. May vary between 60 and 240
- 312. May read "calendar" or "plan"
- 313. May be included or excluded
- 314. May vary between 120 and 240
- 315. May read "calendar" or "plan"
- 316. May be included or excluded
- 317. May vary between \$10,000 and the plan maximum

- 318. May be included or excluded
- 319. May vary between \$500 and \$1000 as mandated by state
- 320. May read "calendar" or "plan"
- 321. \$1,000 or as mandated by state
- 322. May vary between \$150 and \$2,000
- 323. May be included or excluded
- 324. May vary between two or three
- 325. May be included or excluded
- 326. May be included or excluded
- 327. May be included or excluded
- 328. May be included or excluded
- 329. May be included or excluded
- 330. May be included or excluded
- 331. May vary between \$0 and \$500
- 332. May be included or excluded
- 333. May vary between \$0 and \$500
- 334. May be included or excluded
- 335. May vary between \$0 and \$500
- 336. May be included or excluded
- 337. May vary between \$0 and \$500
- 338. May vary between \$0 and \$100
- 339. May vary between \$0 and \$150
- 340. May vary between \$0 and \$500
- 341. May vary between \$0 and \$100
- 342. May vary between \$0 and \$150
- 343. May be included or excluded
- 344. May vary between 70 percent and 100 percent
- 345. May be included or excluded
- 346. May be included or excluded
- 347. May vary between 70 percent and 100 percent
- 348. May be included or excluded

- 349. May be included or excluded
- 350. May vary between 70 percent and 100 percent
- 351. May be included or excluded
- 352. May be included or excluded
- 353. May be included or excluded
- 354. May be included or excluded
- 355. May be included or excluded
- 356. May vary between 80 percent and 100 percent
- 357. May vary between 80 percent and 100 percent
- 358. May be included or excluded
- 359. May be included or excluded
- 360. May vary between \$0 and \$150
- 361. May be included or excluded
- 362. May read either "calendar" or "plan"
- 363. May vary between \$0 and \$150
- 364. May read either "calendar" or "plan"
- 365. May vary to 2 to 3 times individual deductible (see #363)
- 366. May be included or excluded
- 367. May be included or excluded
- 368. May vary between \$0 and \$150
- 369. May be included or excluded
- 370. May read either "calendar" or "plan"
- 371. May vary between \$500 and \$3,000
- 372. May vary between \$1,000 and \$2,500
- 373. May be included or excluded
- 374. May be included or excluded
- 375. May be included or excluded
- 376. May be included or excluded
- 377. May vary between 70 percent and 100 percent
- 378. May vary between 70 percent and 100 percent
- 379. May vary between 70 percent and 100 percent

- 380. May vary between \$25 and \$500
- 381. May vary to provide a combined maximum up to \$500
- 382. May be included or excluded
- 383. May be included or excluded
- 384. May be included or excluded
- 385. May be included or excluded
- 386. May be included or excluded
- 387. May be included or excluded
- 388. May be included or excluded
- 389. May be included or excluded
- 390. May be included or excluded
- 391. May be included or excluded
- 392. May be included or excluded
- 393. May be included or excluded
- 394. May be included or excluded
- 395. May be included or excluded
- 396. May vary between 19 and 27 or as mandated by law
- 397. May be included or excluded
- 398. May vary between 12 and 24 or as mandated by law
- 399. May be included or excluded
- 400. May be included or excluded
- 401. May be included or excluded
- 402. May be included or excluded
- 403. May be included or excluded
- 404. May be included or excluded
- 405. May be included or excluded
- 406. May be included or excluded
- 407. May be included or excluded
- 408. May be included or excluded
- 409. May be included or excluded
- 410. May be included or excluded

- 411. May be included or excluded
- 412. May be included or excluded
- 413. May be included or excluded
- 414. May be included or excluded
- 415. May be included or excluded
- 416. May be included or excluded
- 417. May be included or excluded
- 418. May be included or excluded
- 419. May be included or excluded
- 420. May be included or excluded
- 421. May be included or excluded
- 422. May be included or excluded
- 423. May be included or excluded
- 424. May be included or excluded
- 425. May be included or excluded
- 426. May be included or excluded
- 427. May be included or excluded
- 428. May be included or excluded
- 429. May be included or excluded
- 430. Not variable
- 431. May be included or excluded
- 432. May be included or excluded
- 433. May be included or excluded
- 434. May be included or excluded
- 435. May be included or excluded
- 436. May be included or excluded
- 437. May be included or excluded
- 438. May be included or excluded
- 439. May be included or excluded
- 440. May be included or excluded
- 441. May be included or excluded

- 442. May be included or excluded
- 443. May be included or excluded
- 444. May be included or excluded
- 445. May be included or excluded
- 446. May be included or excluded
- 447. May be included or excluded
- 448. May be included or excluded
- 449. May be included or excluded
- 450. May vary to read any or all coverages listed
- 451. May be included or excluded
- 452. May be included or excluded
- 453. May be included or excluded
- 454. May be included or excluded
- 455. May be included or excluded
- 456. May be included or excluded
- 457. May be included or excluded
- 458. May be included or excluded
- 459. May be included or excluded
- 460. May be included or excluded
- 461. May be included or excluded
- 462. May vary between one and three
- 463. May be included or excluded
- 464. May vary between one and three
- 465. May vary between one and three
- 466. May be included or excluded
- 467. May be included or excluded
- 468. May be included or excluded
- 469. May be included or excluded
- 470. May be included or excluded
- 471. May be included or excluded
- 472. May be included or excluded

- 473. May be included or excluded
- 474. May be included or excluded
- 475. May be included or excluded
- 476. May be included or excluded
- 477. May be included or excluded
- 478. May be included or excluded
- 479. May be included or excluded
- 480. May be included or excluded
- 481. May be included or excluded
- 482. May be included or excluded
- 483. May be included or excluded
- 484. May be included or excluded
- 485. May be included or excluded
- 486. May be included or excluded
- 487. May be included or excluded
- 488. May be included or excluded
- 489. May vary from 90 days to 365 days
- 490. May vary from 60 days to 365 days
- 491. May vary from 90 days to 365 days
- 492. May be included or excluded
- 493. May be included or excluded
- 494. May vary from 90 days to 365 days
- 495. May vary between three and twelve months
- 496. May vary from 90 days to 365 days
- 497. May vary to read "calendar" or "plan"
- 498. May vary to read "calendar" or "plan"
- 499. May vary to read "calendar" or "plan"
- 500. May be included or excluded
- 501. May vary to read "calendar" or "plan"
- 502. May vary to read "calendar" or "plan"
- 503. May be included or excluded

- 504. May vary to read "calendar" or "plan"
- 505. May vary to read "calendar" or "plan"
- 506. May be included or excluded
- 507. May be included or excluded
- 508. May be included or excluded
- 509. May be included or excluded
- 510. May be included or excluded
- 511. May vary to read "calendar" or "plan"
- 512. May vary to read "calendar" or "plan"
- 513. May vary to read "calendar" or "plan"
- 514. May be included or excluded
- 515. May vary based on effective date and calendar or plan year option
- 516. May vary from \$1,000 to \$5,000
- 517. May vary to read "calendar" or "plan"
- 518. May vary based on countries of provider service
- 519. May be included or excluded
- 520. May vary based on countries of provider service
- 521. May be included or excluded
- 522. May vary based on countries of provider service
- 523. May be included or excluded
- 524. May be included or excluded
- 525. May vary based on countries of provider service
- 526. May be included or excluded
- 527. May vary based on countries of provider service
- 528. May be included or excluded
- 529. May be included or excluded
- 530. May be included or excluded
- 531. May be included or excluded
- 532. May be included or excluded
- 533. May be included or excluded
- 534. May be included or excluded

- 535. May be included or excluded
- 536. May be included or excluded
- 537. May vary based on countries of provider service
- 538. May be included or excluded
- 539. May be included or excluded
- 540. May be included or excluded
- 541. May be included or excluded
- 542. May be included or excluded
- 543. May vary between 4 and 8
- 544. Not variable
- 545. May be included or excluded
- 546. May vary between 12 and 24
- 547. May vary between 12 and 24
- 548. May vary from 1 to 4
- 549. May be included or excluded
- 550. May be included or excluded
- 551. May vary between 12 and 24
- 552. May be included or excluded
- 553. May vary between 12 and 24
- 554. May be included or excluded
- 555. May be included or excluded
- 556. May be included or excluded
- 557. May be included or excluded
- 558. May be included or excluded
- 559. May vary between \$400 and plan maximum
- 560. May be included or excluded
- 561. May be included or excluded
- 562. May be included or excluded
- 563. May be included or excluded
- 564. May be included or excluded
- 565. May be included or excluded

- 566. May be included or excluded
- 567. May be included or excluded
- 568. May vary from 4 to 7 or as mandated by law
- 569. May be included or excluded
- 570. May be included or excluded
- 571. May vary between \$100,000 and \$250,000 or plan maximum
- 572. May vary between \$25,000 and \$50,000
- 573. May be included or excluded
- 574. May be included or excluded
- 575. May vary between \$2,500 and \$20,000
- 576. May be included or excluded
- 577. May vary between \$2,500 and \$20,000
- 578. May be included or excluded
- 579. May be included or excluded
- 580. May be included or excluded
- 581. May be included or excluded
- 582. May be included or excluded
- 583. May be included or excluded
- 584. May be included or excluded
- 585. May be included or excluded
- 586. May be included or excluded
- 587. May be included or excluded
- 588. May be included or excluded
- 589. May be included or excluded
- 590. May be included or excluded
- 591. May be included or excluded
- 592. May be included or excluded
- 593. May be included or excluded
- 594. May be included or excluded
- 595. May be included or excluded
- 596. May be included or excluded

- 597. May be included or excluded
- 598. May be included or excluded
- 599. May be included or excluded
- 600. May vary between 30, 60, 90, 180 and 365
- 601. May vary between 3, 6, 9 and 12
- 602. May be included or excluded
- 603. May be included or excluded
- 604. May vary between 3, 6, 9 and 12
- 605. May be included or excluded
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- 622. May vary between 3 and 12
- 623. May be included or excluded
- 624. May be included or excluded
- 625. May be included or excluded
- 626. May vary to read either or both listed
- 627. May vary to read either or both listed

- 628. May vary to read either or both listed
- 629. May be included or excluded
- 630. Not variable
- 631. May be included or excluded
- 632. May be included or excluded
- 633. May be included or excluded
- 634. May be included or excluded
- 635. May vary between 3 and 6 months
- 636. May be included or excluded
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- 650. May be included or excluded
- 651. Benefits may be included or excluded
- 652. May vary between 12 and 24 months
- 653. May be included or excluded
- 654. May vary between 12 and 24 months
- 655. May be included or excluded
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- 686. May be included or excluded
- 687. May be included or excluded
- 688. May vary to read any or all coverages listed
- 689. May be included or excluded

- 690. May vary between 30 days and 90 days based on state mandate
- 691. Not variable
- 692. Will vary between 365 days and 1,095 days or as mandated by state
- 693. May vary as mandated by law
- 694. May vary between \$5,000
- 695. May vary between 2 and 3
- 696. Will vary based on employer name
- 697. Will vary based on plan name
- 698. Will vary based on plan number assigned at issuance
- 699. Will vary based on employer's address/assigned administrator
- 700. Will vary to read employer's assigned identification number
- 701. Will vary to read any or all coverages listed
- 702. Will vary to read any or all coverages listed
- 703. Will vary to read any or all coverages listed
- 704. Will vary to read company of issuance
- 705. Will vary to ready any or all coverages listed
- 706. Will vary to read agent for service of process provided
- 707. May vary to read either sentence listed but not both
- 708. May vary to read "Plan" or "Calendar"
- 709. May vary based on the date of issuance and fiscal plan shown
- 710. May be included or excluded

SERFF Tracking Number: DLAL-126475792 *State:* Arkansas
Filing Company: Delaware American Life Insurance Company *State Tracking Number:* 45230
Company Tracking Number:
TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: Expat Policy Filing
Project Name/Number: Expat Policy Filing/

Note To Filer

Created By:

Rosalind Minor on 05/21/2010 12:37 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/06/2010 12:38 PM

Subject:

Objection letter of 4/1/10

Comments:

As of this date, I have not received a response to my Objection letter of 4/1/10. If a response is not received by May 28th, the filing will be disapproved.

SERFF Tracking Number: DLAL-126475792 State: Arkansas
Filing Company: Delaware American Life Insurance Company State Tracking Number: 45230
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Expat Policy Filing
Project Name/Number: Expat Policy Filing/

Note To Reviewer

Created By:

Julie Sheldon on 04/07/2010 08:18 AM

Last Edited By:

Rosalind Minor

Submitted On:

07/06/2010 12:38 PM

Subject:

Filing Fee

Comments:

Please be advised a check in the amount of \$350.00 for filing fees was mailed on 4/6. The check number: 32445398.

SERFF Tracking Number: DLAL-126475792 *State:* Arkansas
Filing Company: Delaware American Life Insurance Company *State Tracking Number:* 45230
Company Tracking Number:
TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: Expat Policy Filing
Project Name/Number: Expat Policy Filing/

Note To Filer

Created By:

Rosalind Minor on 03/29/2010 03:06 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/06/2010 12:38 PM

Subject:

Filing fee

Comments:

The filing fee for this submission is \$350.00. \$50 per form.

SERFF Tracking Number: DLAL-126475792 *State:* Arkansas
Filing Company: Delaware American Life Insurance Company *State Tracking Number:* 45230
Company Tracking Number:
TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: Expat Policy Filing
Project Name/Number: Expat Policy Filing/

Note To Reviewer

Created By:

Julie Sheldon on 03/26/2010 09:24 AM

Last Edited By:

Rosalind Minor

Submitted On:

07/06/2010 12:38 PM

Subject:

Filing Fees

Comments:

Please provide a fee amount for this filing.

SERFF Tracking Number: DLAL-126475792 State: Arkansas
 Filing Company: Delaware American Life Insurance Company State Tracking Number: 45230
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Expat Policy Filing
 Project Name/Number: Expat Policy Filing/

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/06/2010	G10070- Delam 6/09	Policy/Cont ract/Fratern al Certificate	Expat Policy	Initial		46.500	Delam Expat- Policy.pdf
Approved-Closed 07/06/2010	G10070CR - Delam 6/09	Certificate Group Certificate Rider		Initial		40.500	Delam CERTAMND. pdf
Approved-Closed 07/06/2010	G10070AP P- Delam 6/09	Application/ Enrollment Form	Group Insurance Application	Initial		33.400	Delam Expat- APP.pdf
Approved-Closed 07/06/2010	G10070L- Delam 6/09	Certificate Expat Certificate Life/ADD		Initial		50.900	Delam Expat- Cert Life ADD.pdf
Approved-Closed 07/06/2010	G10070D - Delam 6/09	Certificate Expat Certificate LTD		Initial		54.400	Delam Expat- Cert LTD.pdf
Approved-Closed 07/06/2010	G10070H - Delam 6/09	Certificate Expat Certificate MDV		Initial		54.700	Delam Expat- cert M D V (Variable)1.pdf
Approved-Closed 07/06/2010	G10070PA MD - Delam 6/09	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Group Policy Amendment	Initial		50.300	Delam POLAMND.pdf



DELAWARE AMERICAN LIFE INSURANCE COMPANY

ONE ALICO PLAZA
WILMINGTON, DELAWARE 19801
(302) 661-8000
(Herein called the Insurance Company)

CERTIFICATE OF INSURANCE

for certain Employees of:

{XYZ COMPANY}¹

([a {Participating Employer, Policyholder} effective {August 1, 2006}]²³)

who are insured under Group Policy Number {xxxx }⁴
issued to

{ABC Company}⁵
(the Policyholder)

Delaware American Life Insurance Company hereby certifies that certain benefits provided by the Group Policy are available to Employees of the {Participating Employer, Policyholder} who are in an Eligible Class. Under no circumstances may any insurance become effective prior to the Effective Date as determined in the section of this document entitled Effective Date of Insurance.

INTRODUCTION

ABOUT THIS CERTIFICATE. This Certificate describes group {medical, dental and vision}⁶ insurance the Insurance Company provides to Insured Persons under the Group Policy (herein called "the Policy") issued to the Policyholder.

This document describes the coverage available under the Policy. It becomes an Employee's Certificate of Insurance only after he or she has met the eligibility requirements set forth in the section of this document entitled Eligibility for Insurance.

The coverage is funded through a Group Policy issued to the Policyholder by Delaware American Life Insurance Company.

The terms of the Policy that affect your insurance are contained in the following pages.

This Certificate of Insurance and the following pages will become your Certificate. This Certificate is a part of the Policy.

This Certificate replaces any other that the Insurance Company may have issued to the {Participating Employer, Policyholder} to give to you under the Policy specified herein.

The President and Secretary of Delaware American Life Insurance Company witness this Certificate:

President

Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

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SCHEDULE OF BENEFITS

Eligible Employees: {All active, full-time [{U.S., Expatriate, Third Country National}]²⁵ Employees of the Employer who normally work at least {30 hours per week.}^{26,27}

[Note: [This plan covers only Employees [and their Dependents.]]²⁸ [Any Employees [and their Dependents]]²⁹ who return to the U.S.A. for more than {90 continuous days}³⁰ will be terminated under the plan.]³¹

Waiting Period

[Medical:	{None} ^{32,33}
[Dental:	{None} ^{34,35}
[Vision:	{None} ^{36,37}
[All Benefits:.....	{None} ^{38,39}

[{Open, Annual} Enrollment Period: {November 1 of each succeeding year}⁴⁰
[Open Enrollment Effective Date: {January 1 following the Open Enrollment Period}^{41,42}

[MEDICAL BENEFITS

Classification

[All Eligible Employees [and their Dependents]]^{43,44}

[Preferred Provider Network

The Preferred Provided Network is an arrangement in which a network of Hospitals and Physicians have agreed to provide medical care services to Insured Persons. The Preferred Provided Network is for expenses incurred in the {U.S.A. only}⁴⁵. The Hospitals and Physicians will provide these services according to negotiated fee schedules that are considered full payment for services rendered subject to the plan provisions. An Insured Person has the option to utilize an In-Network or an Out-of-Network provider. Benefits applicable to both types of providers are shown below.

For treatment or care received outside any In-Network geographic service area, benefits for Covered Medical Expenses will be payable at Out-of-Network levels. **However, if treatment is received in an Out-of-Network facility on an involuntary basis (such as loss of consciousness as a result of an Emergency Medical Condition), benefits for Covered Medical Expenses will be payable at In-Network levels.**

For treatment or care received for which there is no contracted In-Network provider, benefits for Covered Medical Expenses will be provided at the In-Network level.

For treatment or care rendered by a radiologist, anesthesiologist or pathologist, the applicable percentage payable will be based on the facility in which the care is received.

The Insurance Company is not engaged in rendering medical advice or treatment to any insured patient. The diagnosis, treatment, therapy or medical attention provided to any insured patient represents the healthcare provider's own professional opinion and does not represent or constitute any healthcare advice from the Insurance Company nor any of its' employees or agents. Neither the Insurance Company nor any of its' employees or agents can be held liable for any claim, demand, action costs or charges arising, incurred or sustained as a result of the healthcare providers' diagnosis, treatment or therapy provided.]⁴⁶

Medical Deductibles

[Individual Medical Deductible Per Insured Person

<u>[In-Network U.S.]</u>⁴⁷	<u>[Out-of-Network U.S.]</u>⁴⁸	<u>[In-Network Non-U.S.]</u>⁴⁹	<u>[Out-of-Network Non-U.S.]</u>⁵⁰
{ \$100 } ⁵¹	{ \$250 } ⁵²	{ \$100 } ⁵³	{ \$250 } ^{54,55}

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

<u>[Family Medical Deductible</u>			
<u>[In-Network U.S.]</u> ⁵⁶	<u>[Out-of-Network U.S.]</u> ⁵⁷	<u>[In-Network Non-U.S.]</u> ⁵⁸	<u>[Out-of-Network Non-U.S.]</u> ⁵⁹
{ \$300 } ⁶⁰	{ \$750 } ⁶¹	{ \$300 } ⁶²	{ \$750 } ^{63,64}

[Air Ambulance Deductible Per Insured Person – [per occurrence]⁶⁵ { \$ 200 }^{66,67}

[In-patient Hospital Deductible Per Insured Person – [per occurrence]⁶⁸ { \$ 200 }^{69,70}

- [NOTES: 1. Charges used to satisfy Deductibles for Covered Medical Expenses incurred in the U.S.A. will [not]⁷¹ be credited to the deductible for Covered Medical Expenses incurred outside the U.S.A..
2. Charges used to satisfy Deductibles for Covered Medical Expenses incurred outside the U.S.A. will [not]⁷² be credited to the Deductible for Covered Medical Expenses incurred in the U.S.A..
- [3. Charges used to satisfy Deductibles for Covered Medical Expenses incurred for treatment by In-Network providers will [not]⁷³ be credited to the Deductible for Covered Medical Expenses incurred for treatment by Out-of-Network providers.
4. Charges used to satisfy Deductibles for Covered Medical Expenses incurred for treatment by Out-of-Network providers will [not]⁷⁴ be credited to the Deductible for Covered Medical Expenses incurred for treatment by In-Network providers.]^{75,76}

[Co pays – Apply only to services indicated below [which have been incurred in the U.S.A.]⁷⁷ After the Co pays the balance is payable at 100% coinsurance.

	<u>[In-Network]</u> ⁷⁸	<u>[Out-of Network]</u> ⁷⁹
1. For Physician Services [incurred in the U.S.A.] ⁷⁸ - [per visit] ⁷⁹	{ \$10 } ⁸⁰	{Ded/Coins.} ⁸¹
2. For Office Visits [incurred in the U.S.A.] ⁸² - [per visit] ⁸³	{ \$10 } ⁸⁴	{Same as network if emergency.} ⁸⁵
3. For Outpatient Psych Services [incurred in the U.S.A.] ⁸⁶ - [per visit] ⁸⁷	{ \$10 } ⁸⁸	{Ded/Coins.} ⁸⁹
4. For Emergency Services [incurred in the U.S.A.] ⁹⁰ - [per visit] ⁹¹	{ \$50 } ⁹²	{Ded/Coins.} ⁹³
5. For Urgent Care Center [incurred in the U.S.A.] ⁹⁴ - [per visit] ⁹⁵	{ \$50 } ⁹⁶	{Ded/Coins.} ⁹⁷
6. For Specialist Office Visit [incurred in the U.S.A.] ⁹⁸ - [per visit] ⁹⁹	{ \$10 } ¹⁰⁰	{Ded/Coins.} ^{101,102}

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Out-of-Pocket Maximums - [This provision does not apply to charges for {Treatment of Mental Illness and/or Substance Abuse, Prescription Drug charges, or to charges for Air Ambulance service}¹⁰³.]¹⁰⁴ The Deductible is [NOT]¹⁰⁵ included in the Out-of-Pocket Maximum.

{Individual Out-of Pocket Maximum Per Insured Person

[In-Network U.S.]¹⁰⁶	[Out-of-Network U.S.]¹⁰⁷	[In-Network Non-U.S.]¹⁰⁸	[Out-of-Network Non-U.S.]¹⁰⁹
{ \$1,000 } ¹¹⁰	{ \$2,500 } ¹¹¹	{ \$1,000 } ¹¹²	{ \$2,500 } ¹¹³ ¹¹⁴

[Family Out-of Pocket Maximum

[In-Network U.S.]¹¹⁵	[Out-of-Network U.S.]¹¹⁶	[In-Network Non-U.S.]¹¹⁷	[Out-of-Network Non-U.S.]¹¹⁸
{ \$3,000 } ¹¹⁹	{ \$7,500 } ¹²⁰	{ \$3,000 } ¹²¹	{ \$7,500 } ¹²² ¹²³

- [NOTES: 1. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred in the U.S.A. will [not]¹²⁴ be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred outside the U.S.A..
2. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred outside the U.S.A. will [not]¹²⁵ be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred in the U.S.A..
- [3. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by In-Network providers will [not]¹²⁶ be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by Out-of-Network providers.
4. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by Out-of-Network providers will [not]¹²⁷ be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by In-Network providers.]¹²⁸

Percentage Payable

[Outpatient Treatment of Mental Illness and/or Substance Abuse

[In-Network U.S.]¹²⁹	[Out-of-Network U.S.]¹³⁰	[In-Network Non-U.S.]¹³¹	[Out-of-Network Non-U.S.]¹³²
{100% after deductible} ¹³³	{70% after Deductible} ¹³⁴	{50% after Deductible} ¹³⁵	{50% after Deductible} ¹³⁶ ¹³⁷

[Inpatient Treatment of Mental Illness and/or Substance Abuse

[In-Network U.S.]¹³⁸	[Out-of-Network U.S.]¹³⁹	[In-Network Non-U.S.]¹⁴⁰	[Out-of-Network Non-U.S.]¹⁴¹
{100% after deductible} ¹⁴²	{70% after Deductible} ¹⁴³	{100% after Deductible} ¹⁴⁴	{100% after Deductible} ¹⁴⁵ ¹⁴⁶

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Percentage Payable (continued)

[Well Baby/Child Care]

[In-Network U.S.]¹⁴⁷ **[Out-of-Network U.S.]**¹⁴⁸ **[In-Network Non-U.S.]**¹⁴⁹ **[Out-of-Network Non-U.S.]**¹⁵⁰
{100% Deductible waived}¹⁵¹ {70% after Deductible}¹⁵² {100% Deductible waived}¹⁵³ {100% Deductible waived}^{154,155}

[Adult Preventive Care]

[In-Network U.S.]¹⁵⁶ **[Out-of-Network U.S.]**¹⁵⁷ **[In-Network Non-U.S.]**¹⁵⁸ **[Out-of-Network Non-U.S.]**¹⁵⁹
{100% Deductible waived}¹⁶⁰ {70% after Deductible}¹⁶¹ {100% Deductible waived}¹⁶² {100% Deductible waived}^{163,164}

[Mammogram Expenses]

[In-Network U.S.]¹⁶⁵ **[Out-of-Network U.S.]**¹⁶⁶ **[In-Network Non-U.S.]**¹⁶⁷ **[Out-of-Network Non-U.S.]**¹⁶⁸
{100% Deductible waived}¹⁶⁹ {70% after Deductible}¹⁷⁰ {100% Deductible waived}¹⁷¹ {100% Deductible waived}^{172,173}

[Prostate Cancer Screenings]

[In-Network U.S.]¹⁷⁴ **[Out-of-Network U.S.]**¹⁷⁵ **[In-Network Non-U.S.]**¹⁷⁶ **[Out-of-Network Non-U.S.]**¹⁷⁷
{100% Deductible waived}¹⁷⁸ {70% after Deductible}¹⁷⁹ {100% Deductible waived}¹⁸⁰ {100% Deductible waived}^{181,182}

[Gynecological Exams]

[In-Network U.S.]¹⁸³ **[Out-of-Network U.S.]**¹⁸⁴ **[In-Network Non-U.S.]**¹⁸⁵ **[Out-of-Network Non-U.S.]**¹⁸⁶
{100% Deductible waived}¹⁸⁷ {70% after Deductible}¹⁸⁸ {100% Deductible waived}¹⁸⁹ {100% Deductible waived}^{190,191}

[Colonoscopy Expenses]

[In-Network U.S.]¹⁹² **[Out-of-Network U.S.]**¹⁹³ **[In-Network Non-U.S.]**¹⁹⁴ **[Out-of-Network Non-U.S.]**¹⁹⁵
{100% Deductible waived}¹⁹⁶ {70% after Deductible}¹⁹⁷ {100% Deductible waived}¹⁹⁸ {100% Deductible waived}^{199,200}

[Lead Screenings]

[In-Network U.S.]²⁰¹ **[Out-of-Network U.S.]**²⁰² **[In-Network Non-U.S.]**²⁰³ **[Out-of-Network Non-U.S.]**²⁰⁴
{100% Deductible waived}²⁰⁵ {70% after Deductible}²⁰⁶ {100% Deductible waived}²⁰⁷ {100% Deductible waived}^{208,209}

[Immunizations]

[In-Network U.S.]²¹⁰ **[Out-of-Network U.S.]**²¹¹ **[In-Network Non-U.S.]**²¹² **[Out-of-Network Non-U.S.]**²¹³
{100% Deductible waived}²¹⁴ {70% after Deductible}²¹⁵ {100% Deductible waived}²¹⁶ {100% Deductible waived}^{217,218}

SCHEDULE OF BENEFITS

(Continued)

MEDICAL BENEFITS (continued)

Percentage Payable (continued)

[Prescription Drugs]
[In-Network U.S.]²¹⁹ [Out-of-Network U.S.]²²⁰ [In-Network Non-U.S.]²²¹ [Out-of-Network Non-U.S.]²²²
 Refer to Prescription Drug Section on Page 6 {100% Deductible waived}²²³ {100% Deductible waived}²²⁴²²⁵

[Diabetic Supplies]

[In-Network U.S.]²²⁶ [Out-of-Network U.S.]²²⁷ [In-Network Non-U.S.]²²⁸ [Out-of-Network Non-U.S.]²²⁹
 {100% Deductible waived}²³⁰ {70% after Deductible}²³¹ {100% Deductible waived}²³² {100% Deductible waived}²³³²³⁴

[Hospital, Surgical and other Covered Medical Expense]

[In-Network U.S.]²³⁵ [Out-of-Network U.S.]²³⁶ [In-Network Non-U.S.]²³⁷ [Out-of-Network Non-U.S.]²³⁸
 {90% after Deductible}²³⁹ {70% after Deductible}²⁴⁰ {100% after Deductible}²⁴¹ {100% after Deductible}²⁴²²⁴³

[However, Deductibles will be waived for expenses incurred in connection with an Accidental Injury that results in an Emergency Medical Condition.]²⁴⁴

[All inpatient Hospital Confinements in the U.S.A. [and air ambulance service anywhere]²⁴⁵ must be pre-certified. See page {32}²⁴⁶ for details and penalties for non-compliance.]²⁴⁷

[Maternity/Obstetrical Charges]

Covered the same as any other condition.]²⁴⁸

Maximum Benefits

Lifetime Maximum Benefit Per Insured Person {\$1,000,000}²⁴⁹
[Lifetime Nursing Services]
 Maximum Per Insured Person {\$25,000}²⁵⁰²⁵¹
[Well-Baby/Child Care Maximum] {Five}²⁵² visits during the first year after birth and {one}²⁵³ visit per year for the following {five}²⁵⁴ years. [\${400}²⁵⁵ {calendar, plan}²⁵⁶ year maximum for {all, each}²⁵⁷ Dependent Children [in any one family]²⁵⁸.]²⁵⁹²⁶⁰
[Adult Preventative Care Maximum] [\${400}²⁶¹ {calendar, plan}²⁶² year maximum for {all, each}²⁶³ Dependent [in any one family]²⁶⁴ [, including the Employee]²⁶⁵.]²⁶⁶²⁶⁷
[Organ Transplants] {\$25,000}²⁶⁸²⁶⁹

SCHEDULE OF BENEFITS

(Continued)

[PRESCRIPTION DRUG BENEFITS (In U.S. Only)]

Classification

[All Eligible Employees [and their Dependents]^{329,330}]

[Deductibles

[Network Retail Pharmacy
 {\$100}^{331,332}]

[Non-Network Retail Pharmacy
 {\$200}^{333,334}]

[Mail Service Network Pharmacy
 {\$300}^{335,336}]

[Co-payments

Network Retail Pharmacy	
Generic Drug	{\$5 - \$30} ³³⁷
Brand Name Drug on Preferred Drug List	{\$5 - \$30} ³³⁸
Brand Name Drug not on Preferred Drug List	{\$5 - \$30} ³³⁹

[Mail Service Network Pharmacy	
Generic Drug	{\$0 - \$30} ³⁴⁰
Brand Name Drug on Preferred Drug List	{\$0 - \$30} ³⁴¹
Brand Name Drug not on Preferred Drug List	{\$0-\$60} ^{342,343}

[Coinsurance

[Network Retail Pharmacy
 {80%}³⁴⁴ Coinsurance [not]³⁴⁵ subject to Medical Deductible]³⁴⁶

[Non-Network Retail Pharmacy
 {80%}³⁴⁷ Coinsurance [not]³⁴⁸ subject to Medical Deductible]³⁴⁹

[Mail Service Network Pharmacy
 {80%}³⁵⁰ Coinsurance [not]³⁵¹ subject to Medical Deductible]^{352,353}

**SCHEDULE OF BENEFITS
(Continued)**

[DENTAL BENEFITS]

Classification

[All Eligible Employees [and their Dependents]^{354,355}]

Percentage Payable

Part I (Preventive) Expense	{ 100% } ³⁵⁶
Part II (Basic) Expense	{ 80% } ³⁵⁷
Part III (Major) Expense	{ 50% } ³⁵⁸
[Orthodontics [(for Dependent Children up to age 19)] ³⁵⁹	{ 50% } ^{360,361}

Dental Deductible

Individual Dental Deductible (per {calendar,plan} ³⁶² year) Per Insured Person	{ \$ 50 } ³⁶³
[Family Dental Deductible (per {calendar,plan} ³⁶⁴ year)	{ \$100 } ^{365,366}
<i>[The Dental Deductible does not apply to Part I (Preventive) Expense.]³⁶⁷</i>	
[Orthodontic Deductible (per lifetime)	{ \$ 50 } ^{368,369}

Maximum Benefits

{Calendar,Plan} ³⁷⁰ Year Maximum Benefit Per Insured Person	{ \$1,000 } ³⁷¹
[Lifetime Orthodontic Maximum Per Insured Person	{ \$1,000 } ^{372,373,374}

[VISION CARE BENEFITS]

Classification

[All Eligible Employees [and their Dependents]^{375,376}]

Schedule of Vision Care Services and Supplies

Percentage Payable

Vision Examination	{100%} ³⁷⁷
Lens	{100%} ³⁷⁸
Frames	{100%} ³⁷⁹

Services and Supplies

Maximum Allowance Per Insured Person

Vision Examination	{ \$ 25.00 } ³⁸⁰
Materials	
[Single Vision Lens	\$ 20.00 per lens
Bi-focal Lens	\$ 40.00 per lens
Tri-focal Lens	\$ 50.00 per lens
Contact Lens	\$ 40.00 per lens
Ventricular Lens	\$ 60.00 per lens
Frames	{ \$ 20.00 } ^{381,382,383}

DEFINITIONS

["**Accidental Injury**"] means bodily Injury caused by an accident occurring while the Policy is in force with respect to the person whose Injury is the basis of claim and resulting directly and independently of all other causes in a covered loss. This includes related conditions and recurrent symptoms of such Injury.]³⁸⁴

["**Acquired Immune Deficiency Syndrome**"] (AIDS) shall have the meanings assigned to it by the World Health Organization. The term opportunistic infection shall include but not be limited to Pneumocystis carini pneumonia, organism of chronic enteritis, virus and/or disseminated fungi infection. The term malignant neoplasm shall include but not be limited to Karposi's sarcoma, central nervous system lymphoma and/or other malignancies now known or which become known as immediate causes of death in the presence of acquired immune deficiency. Acquired Immune Deficiency Syndrome shall include H.I.V. (Human Immune Deficiency Virus), encephalopathy (dementia) and H.I.V. (Human Immune Deficiency Virus) wasting syndrome.]³⁸⁵

["**Acupressure or Acupuncture**"] seeks to remedy illness through either the application of deep finger pressure or needles at points located along an invisible system of energy channels called meridians.]³⁸⁶

["**Active Service**"] An Employee will be considered in Active Service if he or she is performing in the customary manner all of the regular duties of his or her employment on a regularly scheduled work day at his or her usual place of employment or at some location to which the {Participating Employer's, Policyholder's} business requires him or her to travel. An Employee will be considered in Active Service on a regularly scheduled non-work day if he or she was in Active Service on the immediately preceding scheduled work day.

["**Brand Name Drug**"] is a Prescription Drug which is (1) manufactured and marketed under a trademark or name by a specific drug manufacturer; and (2) identified as a Brand Name Drug by the Insurance Company.]³⁸⁷

["**Certificate**"] means a written statement prepared by the Insurance Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an Employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

["**Covered Dental Injury**"] means an Injury caused by a sudden and violent external force. The Injury must be unexpected and unavoidable. A chewing Injury is not a Covered Dental Injury.]³⁸⁸

["**Covered Emergency Evacuation Expense(s)**"] means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.]³⁸⁹

["**Co-payment**"] is a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as \$10 or \$15 Co-payment per office visit). Co-payments, if any, are identified in the Schedule of Benefits.]³⁹⁰

["**Creditable Coverage**"] means an Insured had prior coverage under: A group health benefit plan; A health benefit plan; Part A or Part B of Title XVIII of the U.S. Social Security Act; Title XIX of the U.S. Social Security Act; Chapter 55 of Title 10, United States Code; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; A health plan offered Chapter 89 of Title 5, United States Code; A public health plan as defines in federal regulations; or A health benefit plan under the Peace Corps Act.

DEFINITIONS (Continued)

["Custodial Care"] means care or services which are not intended primarily to treat a specific Injury or Sickness (including Mental Illness and/or Substance Abuse). Custodial Care includes, but is not limited to:

1. services related to watching or protecting a person
2. services related to performing or assisting a person in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting into or out of bed, toileting, eating, preparing foods or taking medications that can usually be self administered; and
3. services not required to be performed by trained or skilled medical or paramedical personnel.]³⁹¹

["Dentist"] means a person other than an Insured Person who: (a) is licensed to practice Dentistry; and (b) practices within the scope of his or her license. A dental hygienist, denturist or Physician will be considered a Dentist when he or she performs any dental service that is within the scope of his or her license.]³⁹²

["Dental Treatment Plan"] means the Dentist's report of recommended treatment on a form accepted by the Sponsor that: (a) itemizes the dental procedures and charges required for the necessary care of the mouth; (b) lists the charges for each procedure; and (c) is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials required by the Insurance Company.]³⁹³

["Dependent"] means an Employee's {Spouse, Domestic Partner, Dependent Child}]³⁹⁴ [who does not reside in the U.S.]³⁹⁵

["Dependent Child"] or **["Dependent Children"]** mean any unmarried child(ren) of the Employee, including a natural, step, foster or adopted child(ren) who is:

1. under {19}³⁹⁶ years of age;
2. 19 years but under 26 years of age, if attending an accredited institution of higher learning on a full time basis) and primarily dependent on the Insured Employee for support and maintenance; or
3. 19 years of age or over and mentally or physically incapable of earning a living and primarily supported by the Insured Employee, provided the Insured Employee submits proof of the child's incapacity and dependency to the Insurance Company within 60 days before the date the Dependent Child fails to qualify under (1) or (2) above. If the Insured Employee fails to furnish the requested proof before the Dependent Child reaches the age limit, coverage for the Dependent Child will not be extended past the age limit. If coverage is extended, the Insurance Company may request that the Insured Employee submit satisfactory proof of the Dependent Child's continued incapacity and dependency to the Insurance Company on an annual basis. If the Insured Employee fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child will terminate at the end of that 31-day period.

* A foster or adopted child meets the definition of dependent the date the child is placed in foster care or placed for adoption.]³⁹⁷

DEFINITIONS (Continued)

["Domestic Partner"] means an opposite or same sex partner who has met all of the following requirements for at least {12}³⁹⁸ consecutive months: (a) resides with the Insured Person at the same permanent residence; (b) is not married to the Insured Person under either statutory or common law; (c) is not related by blood to the Insured Person to a degree of closeness that would prohibit a legal marriage in the jurisdiction in which they reside; (d) is at least the age of consent in the jurisdiction in which they reside; (e) neither the Insured Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner and (f) is financially interdependent with the Insured Person and has provided the {Participating Employer, Policyholder}⁴⁷⁸ with at least two (2) of the following documents evidencing such financial interdependence:

- joint ownership of real property or a common leasehold interest in real property
- common ownership of an automobile
- joint bank account
- a will in which one partner designates the other as primary beneficiary
- a beneficiary designation form for a retirement plan, or life insurance policy signed and completed to the effect that one partner is the primary beneficiary of the other
- if the Insured Person and Domestic Partner reside in a jurisdiction which provides for registration of Domestic Partners, they have so registered and provided the {Participating Employer, Policyholder} with evidence of such registration.

The Insurance Company also requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.]³⁹⁹

["Durable Medical Equipment"] means equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of Sickness or Injury; and (d) is appropriate for use in the home.]⁴⁰⁰

["Emergency Evacuation"] means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness: (1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.]⁴⁰¹

["Emergency Sickness"] means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place their life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom.]⁴⁰²

["Employee"] means a full-time Employee of the {Participating Employer, Policyholder}, including Employees of one or more subsidiary corporations, and the Employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the Employer and such affiliated corporations, proprietorships or partnerships is under common control. Employee shall exclude, in any case, part-time Employees, temporary Employees and Employees who work for the {Participating Employer, Policyholder} [less than the number of hours per week indicated in the Schedule of Benefits]⁴⁰³.

["Employer"] means the {Participating Employer, Policyholder}.

["Evidence of Insurability"] means a statement or medical evidence of health that determines if a person qualifies for coverage under the Policy.

["Expatriate"] means an Employee who is working outside his country of permanent residence.

DEFINITIONS (Continued)

["Free-Standing Surgical Facility"] means an institution which is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions and which: (a) has a medical staff including Physicians, Registered Graduate Nurses and licensed anesthesiologists; (b) maintains at least two operating rooms and one recovery room, diagnostic X-ray and laboratory facilities, equipment for emergency care, a blood supply and medical record-keeping facilities; and (c) has agreements with Hospitals for immediate acceptance of patients requiring Hospital Confinement on an inpatient basis.]⁴⁰⁴

["Generic Drug"] is a Prescription Drug which is: (1) chemically equivalent to a Brand Name Drug whose patent has expired; and (2) identified as a Generic Drug by the Insurance Company.]⁴⁰⁵

["Grace period"] is the 31 days following a premium due date during which premium payment may be made.

["Home Health Aide"] means a certified or trained professional who provides services through a Home Health Care Agency which:

1. are not required to be performed by an RN, LPN or LVN;
2. primarily aid the Insured Person in performing the normal activities of daily living while recovering from an Injury or Sickness; and
3. are described under the Home Health Care Plan.]⁴⁰⁶

["Home Health Care Agency"] means an agency or organization that:

1. is licensed, if required, by the appropriate licensing body to provide home health services and supplies;
2. is primarily engaged in nursing and other therapeutic services;
3. has its policies set up by professionals associated with the agency.]⁴⁰⁷

["Home Health Care Plan"] means a program for continued health care and treatment in the Insured Person's home. It must either (a) follow within 24 hours of and be for the same or related cause(s) as a period of Hospital or Skilled Nursing Facility confinement; or (b) be in lieu of a Hospital or Skilled Nursing Facility confinement. It must be set up, approved in writing and renewed every 60 days by a Physician. Such Physician must certify that the proper treatment would require confinement as an inpatient in a Hospital or Skilled Nursing Facility if the services and supplies were not provided under a Home Health Care Plan. The Physician must also examine the Insured Person at least once a month.]⁴⁰⁸

["Hospice"] means a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent Hospice administration and it helps the patient cope with physical, psychological, spiritual, social and economic stresses. The Hospice administration must meet the standards of the National Hospice Organization and any licensing requirements.]⁴⁰⁹

["Hospice Benefit Period"] means a period that begins on the date the attending Physician certifies that the Insured Person is a terminally ill patient who has less than six months to live. It ends after six months (or such later period for which treatment is certified) or on the death of the Insured Person, if sooner.]⁴¹⁰

DEFINITIONS (Continued)

["Hospice Care Expenses"] are the Reasonable and Customary Charges made by a Hospice for the following services or supplies:

1. charges for inpatient care;
2. charges for drugs and medicines;
3. charges for part-time nursing by an RN, LPN or LVN;
4. charges for physical and respiratory therapy in the home;
5. charges for the use of medical equipment;
6. charges for visits by licensed or trained social workers, Psychologists or counselors;
7. charges for bereavement counseling of the Insured Person's Immediate Family prior to, and within three months after the Insured Person's death.
8. charges for respite care for up to five days in any 30 day period;

The term "respite care" means care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill Insured Person.]⁴¹¹

["Hospital"] means (a) an institution constituted, licensed and operated in accordance with the laws pertaining to Hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of Injury and Sickness, and which provides such treatment for compensation, by or under the supervision of Physicians, on an inpatient basis with continuous 24-hour nursing service by Registered Graduate Nurses; or (b) an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare and is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals; or (c) an institution which specializes in treatment of Mental Illness, alcoholism, drug addiction or other related illness and which provides residential treatment programs, but only if that institution is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions. The term Hospital will also include a Free-Standing Surgical Facility but will not include an institution which is, other than incidentally, a place for rest, a place for the aged, or a nursing home.]⁴¹²

["Hospital Confinement"] or **["Confined In a Hospital"]** an individual will be considered Confined in a Hospital if he or she is a registered bed patient in a Hospital upon the recommendation of a Physician or is an outpatient in a Hospital because of (a) surgery; (b) emergency care of an Injury within 48 hours after the Injury is received; or (c) tests ordered by a Physician as a planned preliminary to inpatient admission to the same Hospital within four days. In addition, an individual will be considered Confined in a Hospital during partial confinement for treatment of Mental Illness, Substance Abuse or other related illness.

For the purpose of determining the benefits payable, two days of partial confinement in a Hospital will be considered one day of Hospital Confinement. Partial confinement means continuous treatment for at least three hours but not more than 12 hours in any 24-hour period.]⁴¹³

["Immediate Family"] includes an Insured Person's Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), aunt, uncle, niece, nephew, or grandchild.]⁴¹⁴

["Infertility"] means the presence of a demonstrated condition recognized by a license Physician and surgeon as a cause of Infertility; or the inability to conceive a Pregnancy or carry a Pregnancy to a live birth after a year or more of sexual relations without contraception.]⁴¹⁵

["Injury"] means bodily injury resulting directly from an accident and independently of all other causes. The Injury must occur and disability must begin while the Employee is insured under this policy.]⁴¹⁶

["Insurance Company"] means Delaware American Life Insurance Company. Any references to the terms "we", "us", and "our" will be deemed references to the Insurance Company.

["Insured"] means an Employee insured under this Policy.

DEFINITIONS (Continued)

["**Insured Dependent**"] means an Insured Dependent Child or an Insured Spouse, for whom premium is paid while covered under the Policy.]⁴¹⁷

["**Insured Dependent Child**" or "**Insured Dependent Children**"] mean the Employee's Dependent Child(ren), for whom premium is paid while covered under the Policy.]⁴¹⁸

"**Insured Employee**" means an Employee for whom premium is paid while covered under the Policy.

"**Insured Person**" means an Insured Employee [or an Insured Dependent]⁴¹⁹.

["**Insured Spouse**"] means the Employee's Spouse, for whom premium is paid while covered under the Policy.]⁴²⁰

["**Key Local National**"] means an Employee of the {Participating Employer, Policyholder} working and residing within his country of permanent residence and who the {Participating Employer, Policyholder} has designated as essential to the management of that country's operation.

"**Late Entrant**" means an Employee [or Dependent]⁴²⁰ who enrolls for contributory coverage more than 30 days after his or her eligibility date.

["**Medically Necessary**"] means that a service or supply is determined by the Insurance Company to be medically appropriate and: (a) necessary to meet the basic health needs of the Insured Person, (b) rendered in the most cost-efficient manner and type of setting appropriate for delivery of the service or supply, (c) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or governmental agencies that are accepted by the Insurance Company, (d) consistent with the diagnosis of the condition, (e) required for reasons other than the convenience of the Insured Person or his or her Physician. The service or supply must also be demonstrated through prevailing peer-review medical literature to be either: safe and effective for treating or diagnosing the Injury or Sickness for which their use is proposed, or safe with promising efficacy (i) for treating a life threatening Injury or Sickness, (ii) in a clinically controlled research setting, and (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

For purposes of this definition, "life threatening" means an Injury or Sickness which is more likely than not to cause death within one year of the date of request for treatment.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury or Sickness does not mean that it is Medically Necessary. The definition of Medically Necessary as used in the Policy relates only to the insurance provided by the Policy and may differ from the way a Physician may define medical necessity.

With respect to confinement in a Hospital as an inpatient, "Medically Necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.]⁴²¹

["**Medically Necessary Emergency Evacuation Service**"] means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.]⁴²²

["**Medicare**"] means the program of medical care benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as amended.]⁴²³

["**Mental Illness**"] means any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors. Also called emotional illness, mental/nervous disorder and psychiatric disorder.]⁴²⁴

DEFINITIONS (Continued)

["**Miscellaneous Services and Supplies**"] includes any charges, other than charges for Room and Board, made by a Hospital on its own behalf for necessary medical confinement. Miscellaneous Services and Supplies will also include any charges, by whomever made, for professional ambulance services to or from the nearest Hospital where the medical care and treatment necessary for the individual can be provided, and any charges, by whomever made, for the administration of anesthetics during the Hospital Confinement, but will not include any charges for special nursing fees, dental fees or medical fees.]⁴²⁵

["**Network Pharmacy**"] is a pharmacy, which has (1), entered into an agreement with the Insurance Company or its designee to provide Prescription Drugs to Insured Persons; (2) has agreed to accept specified reimbursement rates for dispensing Prescription Drugs and (3) has been designated by the Insurance Company as a Network Pharmacy. A Network Pharmacy can be either Retail or a Mail Service Pharmacy.]⁴²⁶

["**Participating Employer**"] means an Employer who is part of a trust established to insure Employees of the Employer or any parent, subsidiary or its affiliated companies under a common control.]⁴²⁷

["**Physician**"] means an individual who is operating within the scope of his or her license and is licensed to prescribe and administer drugs or to perform surgery. **Note:** For the purpose of the Policy, a duly licensed Dentist, chiropractor, podiatrist or other practitioner acting within the scope of their licenses will be considered on the same basis as a Physician to the extent that the services are covered under the Policy.

It will not include an Employee or his or her Spouse, daughter, son, father, mother, sister or brother.]⁴²⁸

["**Podiatry**"] treatment is dedicated to the diagnosis, treatment and prevention of disease and disorders affecting the foot, ankle and lower extremities.]⁴²⁹

"**Policyholder**" may be an Employer, including any parent, subsidiary or affiliated company or the trust which the Employer created or participates in.

"**Pre-existing Condition**" is an Injury or Sickness for which the Insured received medical treatment, consultation, care or services including diagnostics measures, or had taken prescribed drugs or medicines in the {three months}⁴³⁰ prior to the Insured's effective date.

["**Preferred Drug List**"] is a list of drugs selected as providing the highest therapeutic and economic value in their classes.]⁴³¹

["**Pregnancy**"] includes miscarriage, abortion, childbirth or any complications thereof.]⁴³²

["**Prescription Drugs**"] are a medication, product or device which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under the Plan, this definition includes insulin and the following diabetic supplies: insulin syringes with needles; blood testing strips – glucose; urine testing strips – glucose; ketone testing strips and tablets; lancets and lancet devices.]⁴³³

["**Psychologist**"] means an individual who is duly licensed or certified as a Psychologist in those jurisdictions where statutory or nonstatutory licensure or certification exists or, in those jurisdictions where neither exists, an individual who is duly qualified as a professional Psychologist by a recognized psychological association.]⁴³⁴

["**Reasonable and Customary Charge**"] means the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed.]⁴³⁵

["**Registered Graduate Nurse**"] means a professional nurse who has the right to use the title "Registered Nurse" and the abbreviation "R.N."]⁴³⁶

DEFINITIONS (Continued)

["**Room and Board**"] includes all charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.]⁴³⁷

["**Serious Injury**" or "**Serious Sickness**"] mean Injury or Sickness certified as being dangerous to life by a legally qualified medical practitioner.]⁴³⁸

"**Serious Mental Illness**" is defined as schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorder; panic disorder; anorexia nervosa; bulimia nervosa; schizoaffective disorder and delusional disorder.

["**Sickness**"] means any physical Sickness, Mental Illness, Substance Abuse or functional nervous disorder diagnosed by a Physician. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. [The term "Sickness" also includes Pregnancy.]^{439,440}

["**Skilled Nursing Facility**"] means a lawfully operating institution engaged mainly in providing treatment for people convalescing from Injury or Sickness. It must have:

1. organized facilities for medical services; and
2. 24 hour nursing service by RNs; and
3. a capacity of six or more beds; and
4. daily medical records for each patient; and
5. a Physician available at all times.

If a Skilled Nursing Facility does not have semi-private rooms, "semi-private room rate" means 80% of that facility's daily charge for its lowest rate private room.

Skilled Nursing Facility does not include: rest homes, homes for the aged, and places for Custodial Care or detoxification facilities.]⁴⁴¹

["**Spinal Manipulation**"] is a form of manual therapy where an application of forces to structures such as muscles, joints and bones is presented, where the goal is the restoration of normal joint motion and the elimination of pain secondary to disturbed biomechanics.]⁴⁴²

["**Spouse**"] means the Insured Employee's lawful spouse (not including a spouse who is legally separated from the Insured). [The term Spouse will include a Domestic Partner.]^{443,444}

["**Substance Abuse**"] means the overindulgence in and dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health, or the welfare of others.]⁴⁴⁵

["**Temporomandibular Joint Dysfunction**"] is a condition of facial pain in the joints of the lower jaw and is also known as myofascial pain dysfunction syndrome or TMJ.]⁴⁴⁶

"**Third Country National**" means an Employee who works outside his country of permanent residence and outside the {Participating Employer, Policyholder}'s country of domicile.

DEFINITIONS
(Continued)

["Total Disability" or "Totally Disabled"] an Employee will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is completely unable to perform the duties of his or her regular occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit.

[A Dependent will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is unable to engage in the normal activities of a person of the same age and sex.]⁴⁴⁷⁴⁴⁸

["Transportation"] means moving the Insured Person during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.]⁴⁴⁹

"Waiting Period", shown in the Schedule of Benefits, means the continuous length of time an Employee must serve in an eligible class to reach his eligibility date.

ELIGIBILITY FOR INSURANCE

EMPLOYEES

Each Employee in a class of Eligible Employees will become eligible for insurance on the date he or she completes the Waiting Period, if any. Any Waiting Period will be waived for an Employee previously insured under the Policy, whose insurance terminated for a reason other than cancellation of his or her payroll deduction order, if the Employee becomes employed in one of the classes of Eligible Employees within one year after his or her insurance terminates. The classes of Eligible Employees and the Waiting Period are shown in the Schedule of Benefits.

[DEPENDENTS

Each Eligible Employee will be eligible {for Vision Benefits, Dental Benefits and Medical Insurance}⁴⁵⁰ with respect to his or her Dependents on the latest of:

1. the effective date of the Policy; or
2. the date upon which he or she acquires a Dependent; or
3. the effective date of the Employee's insurance under the Policy.]⁴⁵¹

EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]⁴⁵²

EMPLOYEES

[Non-Contributory [- All Coverage's]⁴⁵³

If the {Participating Employer, Policyholder} plan under the Policy or any coverage afforded there under is issued on a non-contributory basis, an Eligible Employee's coverage will become effective on the later of:

1. the effective date of the Policy; or
2. the date such Employee becomes eligible.

[With respect to coverage's other than Medical Insurance,]⁴⁵⁴ if the Employee is not in Active Service on the date insurance would normally become effective; the effective date of his or her insurance will be the date he or she returns to Active Service.]⁴⁵⁵

[Contributory [- Coverage's other than Medical Insurance]⁴⁵⁶

If the {Participating Employer, Policyholder} plan under the Policy or any coverage [other than Medical Insurance]⁴⁵⁷ afforded there under is issued on a contributory basis, each Employee may elect such insurance by signing an enrollment form approved by the {Participating Employer, Policyholder} and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the {Participating Employer, Policyholder} on or before that date; or
2. the date on which the enrollment form is received by the {Participating Employer, Policyholder}, if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the {Participating Employer, Policyholder} more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]^{458,459}

EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]⁴⁶⁰
(continued)

EMPLOYEES (continued)

[Contributory - Medical Insurance

If the {Participating Employer, Policyholder} plan under the Policy or the Medical Insurance afforded there under is issued on a contributory basis, each Employee may elect such insurance by enrolling on a form approved by the {Participating Employer, Policyholder} and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the {Participating Employer, Policyholder} on or before that date; or
2. the date on which the enrollment form is received by the {Participating Employer, Policyholder}, if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which the enrollment form is received by the {Participating Employer, Policyholder}, if that date is within a 30-day Special Enrollment Period; or
4. the date for which the first premium for the Employee's coverage is paid.

If the Employee fails to enroll for contributory Medical Insurance as set forth in 1., 2. or 3. above, such Employee may again enroll for coverage during the 30-day period following the one year anniversary of the date on which he or she was originally eligible or, if later, during the 30-day period following the one year anniversary of the beginning of a Special Enrollment Period.⁴⁶¹

[Open Enrollment. The Open Enrollment Period, shown in the Schedule, is a period of time agreed upon by the {Participating Employer, Policyholder} and the Insurance Company, during which: (a) members of an Eligible Class may apply for insurance; and (b) Insureds may elect to make changes in their amount of insurance or apply for additional insurance. Any changes made during the Open Enrollment Period will take effect on the date shown in the Schedule. Any changes in the amount of insurance during the Open Enrollment will be limited to {one incremental increase}⁴⁶². All other increases will be subject to Evidence of Insurability⁴⁶³

[Annual Enrollment. The Annual Enrollment Period, shown in the Schedule, is a period of time during which any Eligible Insured's may apply for insurance or elect to make changes in their amount of insurance. Any changes in the amount of insurance during an Annual Enrollment will be limited to {one incremental increase}.⁴⁶⁴ Any increase either over the Guarantee Issue or more than the limited change amount will be subject Evidence of Insurability.⁴⁶⁵

[DEPENDENTS

[Non-Contributory [- All Coverage's]⁴⁶⁶

An Insured Dependent's coverage under the Policy will become effective on the later of:

1. the date the Insured Employee becomes eligible for Dependent insurance; or
2. the Insured Employee's effective date of coverage under the Policy.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

[With respect to coverage's other than Medical Insurance,⁴⁶⁷ if a Dependent is Confined in a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.⁴⁶⁸

EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]⁴⁶⁹
(continued)

DEPENDENTS (continued)

[Contributory [- Coverage's other than Medical Insurance]⁴⁷⁰

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder} on or before the date he or she becomes eligible; or
2. the date the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder}, if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. on the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder} more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is Confined in a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.⁴⁷¹

[Contributory - Medical Insurance

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder} on or before the date he or she becomes eligible; or
2. the date the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder}, if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. on the date the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder}, if that date is within a 30 day Special Enrollment Period. Coverage for certain Dependents will be effective earlier. See the following "Special Enrollment Periods" section for details; or
4. the date for which the first premium for the Dependent's coverage is paid.⁴⁷²

[If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.]⁴⁷³

EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]⁴⁷⁴

(continued)

[Special Enrollment Periods

A Special Enrollment Period is a 30-day period during which an Eligible Employee who has previously declined to enroll under the Policy may enroll himself or herself or his or her Dependents. A Special Enrollment Period will be granted under the following conditions:

1. Loss of Other Coverage
 - a. the Eligible Employee or Dependent was covered under another group benefit plan or had health insurance coverage at the time coverage under the Policy was offered; and
 - b. the Eligible Employee declined coverage under the Policy, in writing, on the basis of the other coverage; and
 - c. the Eligible Employee or Dependent lost the other coverage as a result of legal separation, divorce, death, termination of employment or a reduction in the number of hours of employment or Employer contributions toward such coverage were terminated, or
 - d. the Eligible Employee's or Dependent's COBRA coverage is exhausted.

If the Eligible Employee or Dependent lost the other coverage as a result of his or her failure to pay premiums or for cause (including but not limited to making a fraudulent claim), that Eligible Employee or Dependent will not have a Special Enrollment Period.

2. Other

Dependents are entitled to a special 30 day enrollment period if they become Dependents through marriage, birth, adoption or placement for adoption. The effective date of coverage for such a Dependent will be retroactive to the date of marriage, birth, adoption or placement for adoption.⁴⁷⁵

[EFFECTIVE DATE OF INSURANCE [- NON- U.S. CITIZENS]⁴⁷⁶

EMPLOYEES

[Non-Contributory [- All Coverage's]⁴⁷⁷

If the {Participating Employer, Policyholder} plan under the Policy or the coverage afforded there under is issued on a non-contributory basis, an Eligible Employee's coverage will become effective on the later of:

1. the effective date of the Policy; or
2. the date such Employee becomes eligible for coverage under the Policy.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]^{478,479}

[Contributory [- All Coverage's]⁴⁸⁰

If the {Participating Employer, Policyholder} plan under the Policy or any coverage afforded there under is issued on a contributory basis, each Employee may elect for such insurance by signing an enrollment form approved by the {Participating Employer, Policyholder} and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the {Participating Employer, Policyholder} on or before that date; or
2. the date on which the enrollment form is received by the {Participating Employer, Policyholder}, if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the {Participating Employer, Policyholder} more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

[EFFECTIVE DATE OF INSURANCE [- NON- U.S. CITIZENS]⁴⁸¹

If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]^{482,483}

[DEPENDENTS

[Non-Contributory [- All Coverage's]⁴⁸⁴

An Insured Dependent's coverage under the Policy will become effective on the later of:

1. the date the Insured Employee becomes eligible for Dependent insurance; or
2. the Insured Employee's effective date of coverage under the Policy.]⁴⁸⁵

[Contributory [- All Coverage's]⁴⁸⁶

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder} on or before the date he or she become eligible for coverage under the Policy; or
2. the date the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder}, if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the {Participating Employer, Policyholder} more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is confined to a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.]^{487,488}

TERMINATION OF INSURANCE

EMPLOYEES

An Insured Employee's coverage under the Policy will automatically terminate on the earliest of:

1. the date the Employee ceases to be in a class of Eligible Employees or ceases to qualify as an Employee;
2. the date the Employee's Employer ceases to be a {Participating Employer, Policyholder}] under the Policy;
3. the date the Policy is discontinued;
4. the last day for which any required contribution has been made;
5. {90 days}⁴⁸⁹ after the date the Employee returns to the U.S to establish residency;
6. the date the Employee ceases to be in Active Service, except as provided below:

Temporary Layoff or Leave of Absence. If an Employee's Active Service terminates because of temporary layoff or leave of absence, the insurance will be continued until the {Participating Employer, Policyholder} ceases to pay premiums for the Employee or otherwise cancels the insurance. But in no event will the insurance be continued for more than {60 days}⁴⁹⁰ following termination of Active Service.

Any continuation of insurance must be in accordance with a plan which precludes individual selection.

[DEPENDENTS

An Insured Dependent's coverage under the Policy will automatically terminate upon the earliest of the following:

1. the date the Insured Employee's coverage under the Policy ends; or
2. the last day for which any required contribution has been made;
- [3. {90 days}⁴⁹¹ after the date the Dependent returns to the U.S to establish residency;]⁴⁹²
4. the date the person ceases to qualify as a Dependent.]⁴⁹³

[CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

This provision describes an Insured Person's rights under COBRA to continue the medical coverage which would otherwise terminate under the Policy.

Coverage for an Insured Person will be continued for the applicable Continuation Period described below if insurance under the Policy is terminated due to one of the Qualifying Events described below. The continued coverage will be at the Insured Person's expense and will be identical to the coverage provided under the Policy at the time of the Qualifying Event. If more than one Qualifying Event occurs, coverage may be extended only for the longest Continuation Period for which the Insured Person is eligible under the terms of this provision.

Continuation Periods and Qualifying Events

18-Month Continuation Period

For any Insured Person, coverage may be continued for up to 18 months if coverage would otherwise terminate under the Policy due to one of the following Qualifying Events:

1. voluntary or involuntary termination of employment, other than for gross misconduct; or
2. reduction in work hours.

11-Month Extension for Disability

The 18-month Continuation Period described above may be extended for an additional 11 months if at the time of the Qualifying Event described above (or at any time during the first 60 days of continued coverage), the Insured

**CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS
BUDGET RECONCILIATION ACT (COBRA)
(continued)**

Person is determined to be disabled by the Social Security Administration. This 11-month extension applies to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment.

36-Month Continuation Period for Dependents Only

Coverage for an Insured Dependent may be continued for up to 36 months, if coverage would otherwise terminate due to the following Qualifying Events:

1. the Employee's death;
2. the divorce or legal separation of the Employee and his or her Insured Dependent Spouse;
3. the Employee's child no longer meets the Policy's definition of Dependent.
4. the Employee becomes entitled to Medicare.

If the Employee does not lose coverage due to Medicare entitlement but later loses coverage due to another Qualifying Event (such as voluntary or involuntary termination or reduction in work hours), coverage for Insured Dependents in such cases may be continued for up to 36 months from the date the Employee first became entitled to Medicare.

A child who is born to or placed for adoption with the Insured Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the COBRA administrator of the birth or adoption.

Election Period

For COBRA continuation of coverage to become effective, an Insured Person eligible for the continuation described above must elect the continuation in writing within 60 days of the later of:

1. the date the Insured Person would otherwise lose coverage due to the Qualifying Event; or
2. the date the Insured Person is notified of the right to elect the continuation of coverage.

The election must be in writing on a form provided by the COBRA administrator designated by the {Participating Employer, Policyholder}. The form must be completed and returned within the 60-day period indicated above.

If the Qualifying Event is divorce, legal separation, or a child who no longer qualifies as a Dependent under the Policy, the Insured Person must provide notification within 60 days of the date he or she would lose coverage.

If the Insured Person is disabled and qualifies for continued coverage under the 11-month Extension for Disability described above, the Insured Person must notify the COBRA administrator within 60 days of the final determination by the Social Security Administration that he or she is disabled.

Payment of Premium

The Insured Person who has elected to continue coverage shall be solely responsible for the payment of premium for the continued coverage. If election of COBRA continuation is made after the date of the Qualifying Event, premium payment for the continuation of coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments.

**CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS
BUDGET RECONCILIATION ACT (COBRA)
(continued)**

Termination of COBRA Continuation

The continued coverage will cease on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium is due and unpaid after any applicable Grace Period;
3. the date the Insured Person becomes covered under another group health insurance plan. This may not apply if the Insured Person has a Pre-existing Condition which was covered under the Policy but is not covered under the new plan. However, for plan years beginning after July 1, 1997, if the new plan's Pre-existing Condition exclusion would not apply because your Creditable Coverage under the Policy satisfies the new plan's requirements, then coverage under the Policy pursuant to COBRA may be terminated;
4. the date the Insured Person becomes eligible under Medicare;
5. the date the applicable period of continuation is exhausted, or the Lifetime Maximum Benefit under the Policy, if applicable, is paid on behalf of the Insured Person;
6. the date the Insured Person returns and sets up residency in the U.S. for more than {90 continuous days}⁴⁹⁴;
7. the first day of the month which begins 30 days after the date the Insured Person receives a final determination from the Social Security Administration that he or she is no longer disabled if continued for the 11-month Extension for Disability described above.]

[{THREE}]⁴⁹⁵ MONTH CONTINUATION OF HEALTH INSURANCE COVERAGE

This provision describes an Insured Person's rights to continue the medical coverage which would otherwise terminate under the Policy.

Subject to continued premium payment by the {Participating Employer, Policyholder}, coverage for an Insured Person will be continued for a period of three months if insurance under the Policy is terminated due to one of the Qualifying Events described below. The continued coverage will be identical to the coverage provided under the Policy at the time of the Qualifying Event.

Qualifying Events

For any Insured Person, coverage may be continued if coverage would otherwise terminate under the Policy due to one of the following Qualifying Events:

1. voluntary or involuntary termination of employment, other than for gross misconduct; or
2. reduction in work hours.

Coverage for an Insured Dependent may be continued if coverage would otherwise terminate due to the following Qualifying Events:

1. the Employee's death;
2. the divorce or legal separation of the Employee and his or her Insured Dependent Spouse;
3. the Employee's child no longer meets the Policy's definition of Dependent.
4. the Employee becomes entitled to Medicare.

A child who is born to or placed for adoption with the Insured Employee during a period of continued coverage will be eligible to become a qualified beneficiary. These qualified beneficiaries can be added to continued coverage upon proper notification to the plan administrator of the birth or adoption.

Election Period

For continuation of coverage to become effective, an Insured Person eligible for the continuation described above must elect the continuation in writing within 31 days of the later of:

1. the date the Insured Person would otherwise lose coverage due to the Qualifying Event; or
2. the date the Insured Person is notified of the right to elect the continuation of coverage.

The election must be in writing on a form provided by the {Participating Employer, Policyholder} . The form must be completed and returned within the 31-day period indicated above.

If the Qualifying Event is divorce, legal separation, or a child who no longer qualifies as a Dependent under the Policy, the Insured Person must provide notification within 31 days of the date he or she would lose coverage.

Termination of Continued Coverage

The continued coverage will cease on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium is due and unpaid after any applicable Grace Period;
3. the date the Insured Person becomes covered under another group health insurance plan.
4. the date the Insured Person becomes eligible under Medicare;
5. the date the Insured Person returns and sets up residency in the U.S. for more than {90 continuous days}⁴⁹⁶;
6. the date the three month period of continuation is exhausted, or the Lifetime Maximum Benefit under the Policy, if applicable, is paid on behalf of the Insured Person.]

[MEDICAL BENEFITS

Medical Benefits are payable for expenses incurred by each person while insured under the Policy. Such expenses must be for medical treatment that results from Injury or Sickness. Such expenses must also be Medically Necessary and prescribed or ordered by a Physician.

Medical Benefits are determined this way:

1. Subtract any Medical Deductible from Covered Medical Expenses incurred; and
2. Multiply the result by the Percentage Payable that applies to the Covered Medical Expenses.

Medical Benefits payable will not exceed any of the applicable maximum benefits.

Deductibles, Percentage Payable and maximum benefits are shown in the Schedule of Benefits.

Medical Deductible(s)

Individual Medical Deductible

The Individual Medical Deductible, shown in the Schedule of Benefits, applies to each Insured Person once each {calendar}⁴⁹⁷ year. It is a dollar amount of Covered Medical Expenses for which no benefits are payable.

[Family Medical Deductible

If, in any {calendar}⁴⁹⁸ year, Covered Medical Expenses used toward the Individual Medical Deductibles of an Insured Employee and his Insured Dependents equals the Family Medical Deductible shown in the Schedule of Benefits, the Individual Deductible will be deemed to be met with respect to Covered Medical Expenses incurred by such Insured Employee and his Insured Dependents for the rest of that {calendar}⁴⁹⁹ year.]⁵⁰⁰

[CREDIT FOR MEDICAL DEDUCTIBLE(S). Covered Medical Expenses which were applied toward the Medical Deductible(s) during the last three months of a {calendar}⁵⁰¹ year will be applied to the Medical Deductible(s) of the next {calendar}⁵⁰² year.]⁵⁰³

[COMMON ACCIDENT. If an Insured Employee and one or more of his or her Insured Dependents or if two or more of an Insured Employee's Insured Dependents sustain Injuries in the same accident and, as a result of those Injuries, incur Covered Medical Expenses during the same {calendar}⁵⁰⁴ year in which the accident occurs, only one Medical Deductible will be deducted from the total Covered Medical Expenses incurred for those individuals during the remainder of that {calendar}⁵⁰⁵ year.]⁵⁰⁶

Out-of-Pocket Maximum - [Does not apply to charges for Treatment of Mental Illness and/or Substance Abuse [or to charges for Air Ambulance service]⁵⁰⁷.]⁵⁰⁸ [The Deductible is [NOT]⁵⁰⁹ included in the Out-of-Pocket Maximum.]⁵¹⁰

Individual Out-of-Pocket Maximum

If out-of-pocket expense used to meet the percentage of Covered Medical Expenses that an Insured Employee pays due to the Percentage Payable provision exceeds the Individual Out-of-Pocket Maximum for himself or one of his or her Insured Dependents, Medical Benefits for that one Insured Person will be payable at 100% of such Covered Medical Expense. The Individual Out-of-Pocket Maximum applies on a {calendar}⁵¹¹ year basis. It is shown in the Schedule of Benefits.

[Family Out-of-Pocket Maximum

If out-of-pocket expense used to meet the percentage of Covered Medical Expenses that an Insured Employee pays due to the Percentage Payable provision exceeds the Family Out-of-Pocket Maximum for all Insured Persons in a family in any {calendar}⁵¹² year, Medical Benefits will be payable at 100% of Covered Medical Expense for the rest of that {calendar}⁵¹³ year. The Family Out-of-Pocket Maximum is shown in the Schedule of Benefits.]⁵¹⁴

MEDICAL BENEFITS (Continued)

Percentage Payable

Medical Benefits are paid at percentages of Covered Medical Expenses incurred. These percentages are called the "Percentage Payable". Where the Percentage Payable is less than 100%, the Insured Person is responsible for the difference. The Percentage Payable is shown in the Schedule of Benefits.

Maximum Benefits

Lifetime Maximum Benefit

The Lifetime Maximum Benefit, shown in the Schedule of Benefits, applies to each Insured Person. It is the total of benefits payable for Covered Medical Expenses.

Reinstatement of Lifetime Maximum Benefit

Benefits paid are deducted from the Lifetime Maximum Benefit. Benefits are automatically reinstated {each year on January 1, on the beginning of the plan year}⁵¹⁵. The amount reinstated is the lesser of:

1. {\$1,000}⁵¹⁶; or
2. the amount paid for all charges incurred in the prior {calendar, plan}⁵¹⁷ year.

This is added to the unused amount of the Lifetime Maximum Benefit.

Other Maximums

In addition to the Lifetime Maximum Benefit, certain Covered Medical Expenses are also subject to other internal limits or maximums. These additional maximums are shown in the Schedule of Benefits.

[Pre Certification for {U.S. or Canadian}⁵¹⁸ Hospital Confinements [and any Air Ambulance Service]⁵¹⁹

Pre certification is a program in which the Insurance Company reviews all inpatient Hospital treatment in the {U.S. or Canada}⁵²⁰ [and any request for air ambulance service for medical necessity]⁵²¹.

Under this program, all {U.S., or Canadian}⁵²² inpatient Hospital Confinements [and all requests for air ambulance service]⁵²³ must be certified by the Insurance Company. Procedures for requesting certification are outlined below. ***If an Insured Person fails to follow these procedures, benefits payable for Covered Medical Expenses for charges incurred in connection with the Hospital Confinement [or air ambulance service] will be reduced to 50% of what would otherwise be payable.*** Expenses for charges incurred that are not payable because of this penalty are not Covered Medical Expenses and won't count toward the Out-of-Pocket Maximums.

Non-Emergency Hospitalization [or Air Ambulance Service]⁵²⁴

All non-emergency inpatient Hospital admissions {in the U.S., or Canada}⁵²⁵ [and requests for air ambulance service anywhere]⁵²⁶ must be certified in advance by the Insurance Company. An Insured Person or his or her attending Physician must call the Insurance Company for certification at least five calendar days before a non-emergency {U.S., or Canadian}⁵²⁷ inpatient Hospital admission [or scheduled air ambulance service]⁵²⁸. If the Insurance Company determines that the admission or service is Medically Necessary, the Insured Person will be notified that the Hospital admission [or air ambulance service]⁵²⁹ has been certified. If the admission [or service]⁵³⁰ is not authorized, the Insured Person will be advised of this determination. If the Insured Person does not receive notification prior to the scheduled admission or service date, he or she should contact the Insurance Company to determine the recommendation that it has taken with respect to that Hospital admission [or request for air ambulance service]⁵³¹.

MEDICAL BENEFITS (Continued)

Pre-Admission Certification (continued)

Emergency Hospitalization [or Air Ambulance Service]⁵³²

In an emergency Hospital admission [or emergency air ambulance service]⁵³³, a request to certify must be made within 48 hours or on the next business day following the Insured Person's admission [or air ambulance service]⁵³⁴. "Emergency admission [or air ambulance service]"⁵³⁵ means an inpatient Hospital admission [or air ambulance service]⁵³⁶ for an Emergency Medical Condition.

Important Note

Obtaining a Pre-Admission Certification does not guarantee that the expense will be reimbursed should the expense not be covered for any other reason set forth in this Policy. The Insurance Company reserves the right to review each claim for its' eligibility, and non-eligible expenses shall be denied.

If an Insured Person proceeds with a {U.S. ,or Canadian}⁵³⁷ inpatient Hospital [or an air ambulance service]⁵³⁸ which has been determined as not Medically Necessary, and if a post claim review confirms this determination; no benefits are payable for any charges incurred in connection with that confinement [or service]⁵³⁹.⁵⁴⁰

Covered Medical Expenses

The term Covered Medical Expenses means expenses incurred by or on behalf of an Insured Person for the charges listed below but only if: (a) the expenses are Medically Necessary; and (b) the treatment giving rise to the expenses is prescribed or ordered by an attending Physician. Covered Medical Expense will not include amounts in excess of the Reasonable and Customary Charge. Covered Medical Expenses will be subject to any applicable limitations or maximums shown in the Schedule of Benefits.

The date the service is performed or the supply is purchased is the date Covered Medical Expense is incurred.

1. charges made by a Hospital, on its own behalf, for Room and Board and other Miscellaneous Services and Supplies and for medical care and treatment provided on an outpatient basis;
2. charges made by a facility licensed to furnish treatment of Mental Illness or Substance Abuse, on its own behalf for care and treatment provided on an inpatient basis;
3. charges made by a facility licensed to furnish treatment of Mental Illness or Substance Abuse, on its own behalf for care and treatment provided on an outpatient basis;
4. charges made by a Free-Standing Surgical Facility for services in connection with outpatient surgery, and which are incurred on the day of the surgery or within 48 hours after the surgery;
5. charges for Scalp Hair Prosthesis for hair loss suffered as a result of alopecia areata;
6. charges for an individual hearing aid , per ear, every 3 years, for children less than 24 years of age, covered as a dependent
6. charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment;

MEDICAL BENEFITS
(Continued)

Covered Medical Expenses (continued)

7. charges made by a Home Health Care Agency for treatment rendered in an Insured Person's home pursuant to a Home Health Care plan. Covered Medical Expenses for Home Health Care are limited to the following:
- (a) part-time or intermittent nursing care by or under the supervision of an RN, LPN or LVN;
 - (b) part-time Home Health Aide services that consist primarily of caring for the patient;
 - (c) services provided by a licensed or certified midwife or nurse midwife;
 - (d) medical social services by licensed or trained social workers, Psychologists or counselors;
 - (e) services by licensed physical, occupational or speech therapists;
 - (f) nutrition services provided by a licensed dietitian;
 - (g) medical supplies attendant to the above services to the extent they are covered under the Policy;

Provided further, that in determining the limit of benefits for services in (a) through (e) above:

- (i) each visit by a member of a home health care team (other than a Home Health Aide) will be counted as one home health care visit; and
 - (ii) four hours or less of Home Health Aide service will be counted as one home health care visit;
8. charges for a Physician's professional services including those of a licensed midwife. Charges made by an assistant surgeon or surgical assistant are Covered Medical Expense when such assistance is: (a) Medically Necessary; (b) such person actively participates in the surgery; and (c) such person is not an Employee of the facility where surgery is performed. Charges made by an assistant surgeon or surgical assistant in excess of 20% of the Reasonable and Customary surgeon's charge for the surgery are not covered;
9. charges made by a Registered Graduate Nurse for professional outpatient nursing services;
10. charges made for anesthesia and its administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental of an oxygen breather; diabetic supplies or other Durable Medical Equipment; physical therapy; prosthetic appliances; dressings; and drugs and medicines lawfully obtainable only upon the written prescription of a Physician;
11. Charges made by a Hospice for Hospice Care Expense incurred by a terminally ill Insured Person during a Hospice Benefit Period;
12. charges for professional ambulance service in connection with an Emergency Medical Condition. Covered Medical Expenses for the service are limited to charges for land Transportation to the nearest Hospital equipped to render treatment for the condition. [Air Transportation is covered only when Medically Necessary.]⁵⁴¹
13. [Oral Contraceptive Drugs or devices used to prevent Pregnancy.]⁵⁴²
14. [Treatment of Infertility subject to any maximums indicated on the Schedule of Benefits. [However, services for In Vitro Fertilization are limited to {four}⁵⁴³ eggs per lifetime, are not subject to the Schedule of Benefit maximums, and the following criteria must be met before these services are covered:
- The patient's eggs must be fertilized with her Spouse's sperm;
 - The patient is unable to get pregnant through less expensive covered treatments;
 - The In Vitro Fertilization must be performed at facilities that conform to standards set by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.
 - The patient and his or her Spouse must have at least a {five-year}⁵⁴⁴ history of Infertility; or their Infertility must be associated with one or more of the following conditions:
 - * Endometriosis;
 - * Fetal exposure to diethylstilbestrol, also known as DES; or
 - * Blocked or surgically removed fallopian tubes.]⁵⁴⁵

MEDICAL BENEFITS (Continued)

[Adult Preventive Care Benefits

Benefits are payable for charges incurred by a Insured Person for certain health examinations that are not due to an Injury or Sickness, subject to any limitations or maximums shown in the Schedule of Benefits. Charges for examinations that diagnose Injury or Sickness will be considered as due to and part of the treatment of the diagnosed condition and will not be considered Covered Medical Expenses under this provision.

Covered Expenses:

The following will be considered Covered Medical Expense under this provision:

1. charges for routine general physical examinations not to exceed:
 - one examination in any {24}⁵⁴⁶ consecutive month period for persons age 18 through age 64;
 - one examination in any {12}⁵⁴⁷ consecutive month period for persons age 65 or older;
- [2. charges for Papanicolaou's (Pap) tests; , not to exceed {one}⁵⁴⁸ in any 12 consecutive month period;]⁵⁴⁹
3. charges for electrocardiograms (EKG);
4. charges for X-ray examinations and laboratory tests;
- [5. charges for routine mammography screening as follows:
 - for women age 35 through age 39, one baseline mammogram;
 - for women age 40 through age 49, one baseline mammogram every one or two years, based upon recommendation of a Physician
 - for women age 50 or older, one mammogram every year;
 - for women based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population, one mammographic examination;]⁵⁵⁰
- [6. charges for routine ear examination when performed by an audiologist or otolaryngologist, not to exceed {one in any 24 consecutive month period;}]⁵⁵¹]⁵⁵²
- [7. charges for routine eye examination when performed by an optometrist or ophthalmologist, not to exceed {one in any 24 consecutive month period;}]⁵⁵³]⁵⁵⁴
- [8. charges for prostate cancer screening (PSA) test for men being age 50 or older;]⁵⁵⁵
- [9. charges for CA-125 monitoring of ovarian cancer subsequent to treatment;]⁵⁵⁶
- [10. charges for immunizations including travel immunizations;]⁵⁵⁷
- [11. for persons age 50 or older, screening with annual fecal occult blood tests (3 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable screening tests available.]⁵⁵⁸

Exceptions:

[Additional Benefits (Not Subject to {\$400.00}⁵⁵⁹ Calendar Year Maximum):

The following will be considered Additional Benefits under this provision:

- [1. charges for Papanicolaou's (Pap) tests, not to exceed one in any 12 consecutive month period;]⁵⁶⁰
- [2. charges for routine mammography screening as follows:
 - For women age 35 through 39, one baseline mammogram;
 - For women age 40 through 49, one baseline mammogram every two years, based upon recommendation of a Physician
 - For women age 50 or older, one mammogram every year;
 - For women based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population, one mammographic examination;]⁵⁶¹
- [3. charges for immunizations including travel immunizations;]⁵⁶²
- [4. charges for prostate cancer screening (PSA) test for men being age 40 or older;]⁵⁶³
- [5. charges for CA-125 monitoring or ovarian cancer subsequent to treatment;]⁵⁶⁴
- [6. for persons age 50 or older, screening with annual fecal occult blood tests (3 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable screening tests available.]⁵⁶⁵]⁵⁶⁶

The following are not considered Covered Medical Expenses under this provision:

1. charges for tests or examinations that diagnose Injury or Sickness;

2. charges for tests or examinations given while the Insured Person is Confined in a Hospital or other medical facility.]⁵⁶⁷

MEDICAL BENEFITS (Continued)

[Coverage for Routine Newborn Care

Benefits are payable for routine charges incurred by an Insured Employee's newborn child as follows, subject to any limitations or maximums shown in the Schedule of Benefits:

1. Hospital charges for routine nursery care during the mother's confinement, not to exceed {four}⁵⁶⁸ days;
2. Physician's charges for circumcision;
3. Physician's charges for visits to the newborn child in the Hospital;
4. Benefits for hearing loss screening tests provided by a Hospital before discharge.]⁵⁶⁹

[Well Baby/Child Care

Charges incurred for routine preventive care and immunizations of an Insured Dependent Child who is under eighteen years of age will be considered Covered Medical Expense under the Policy even though such charges are not the result of an Injury or Sickness.

Charges for a baseline lead poisoning screening test for children at or around 12 months of age along with lead poisoning screening and diagnostic evaluations for children under the age of six years who are at high risk for lead poisoning.

Benefits are subject to any limitations or maximums shown in the Schedule of Benefits.]⁵⁷⁰

[EMERGENCY MEDICAL EVACUATION BENEFITS

If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside of his or her country of citizenship, the Insurance Company will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to {\$250,000}⁵⁷¹ for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. An Emergency Evacuation must be ordered by the Insurance Company or a Physician who certifies that the severity or the nature of such person's Injury or Sickness warrants such person's Evacuation.

Covered expenses are those for Transportation and medical treatment, including medical services and medical supplies necessarily incurred in connection with an Insured Person's Emergency Evacuation. All Transportation arrangements made for evacuating such person must be by the most direct and economical route possible. Expenses for Transportation must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting such person; and (c) arranged and authorized in advance by the Insurance Company.

[Repatriation of Remains

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside his or her country of citizenship, the Insurance Company will pay for covered expenses reasonably incurred to return his or her body to his or her country of citizenship, up to {\$25,000}⁵⁷².]⁵⁷³

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for Transportation of the remains; and (3) Transportation of the remains by the most direct and economical conveyance and route possible.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.]⁵⁷⁴

**MEDICAL BENEFITS
(Continued)**

[Emergency Family Travel]

If an Insured Person is hospitalized for more than 5 days, the Insurance Company will pay up to {\$10,000}⁵⁷⁵ for the cost of round-trip economy airfare to bring a person chosen by the Insured Person to and from such Insured Person's bedside if such person is alone.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.]⁵⁷⁶

[Return of Dependents]

If an Insured Person is hospitalized for more than 3 days, the Insurance Company will pay up to {\$10,000}⁵⁷⁷ for the cost of economy airfare for Transportation of the Insured Dependent to his or her country of citizenship or otherwise designated location. This will include an escort to accompany an otherwise unaccompanied minor Dependent Child during the journey.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.]⁵⁷⁸

Exclusions and Limitations

In addition to the provisions of the Policy titled "Medical Exclusions" and "General Limitations, the following will apply solely to the benefits afforded under the Emergency Medical Evacuation Benefits:

No benefits are payable for:

- [Claims arising from depression or anxiety, mental or nervous disorder, alcohol or drug abuse addiction or overdose;]⁵⁷⁹
- [Claims arising from elective cosmetic or plastic surgery, except as a result of an accident;]⁵⁸⁰
- [Claims arising from Pregnancy and all related conditions;]⁵⁸¹
- [a Pre-existing Condition as defined in the Policy;]⁵⁸²
- [an Insured Person traveling against the advice of a Physician;]⁵⁸³
- [Claims directly caused by or directly resulting from:
 - a. any business or financial contractual obligations of the Insured Person or Insured Person's Immediate Family Member;
 - b. Change of plans or disinclination of the Insured Person or Insured Person's Immediate Family Member to travel.]⁵⁸⁴]⁵⁸⁵

**MEDICAL BENEFITS
(Continued)**

[PRESCRIPTION DRUG BENEFITS

Benefits are payable for outpatient Prescription Drugs obtained in the U.S. only. Prescription Drugs obtained outside the U.S. are covered under the Medical Benefits. The Prescription Drugs must be prescribed for:

- Medically Necessary treatment of an Accidental Injury, Sickness or Pregnancy.
- [Prevention of Pregnancy.]⁵⁸⁶

[If the Prescription Drug is a Brand Name Drug, the Co-payment is lower for the preferred version of a dual-marketed drug. Brand Name Drugs, which are not on the Preferred Drug List, are subject to a higher Co-payment.]⁵⁸⁷

[Certain Prescription Drugs require Prior Authorization by a Pharmacist or Physician from the Insurance Company or its designee.]⁵⁸⁸

The Insured Person must be covered under this Prescription Drug Benefit when the prescription is filled.

Network Pharmacy

When a Network Pharmacy is used, the Insured Person pays the Co-payment. Co-payment amounts are shown above.

If the Prescription Drug Cost is less than the Co-payment, the Co-payment does not apply and the Insured Person pays the Prescription Drug Cost.

Network Pharmacies dispense Generic Drugs whenever possible.

For Generic Drugs, an Insured Person pays the Generic Drug Co-payment.

[An Insured Person pays the Brand Name Drug Co-payment for Brand Name Drugs dispensed under either of the following conditions:

- There is no equivalent Generic Drug for substitution.
- The Physician orders a Brand Name Drug. This is usually done by writing "Dispense as written" on the prescription.]⁵⁸⁹

[For Brand Name Drugs which do not have a Generic Drug equivalent, an Insured Person pays the Brand Name Drug Co-payment.]⁵⁹⁰

[For all other Brand Name Drugs, an Insured Person pays:

- The Generic Drug Co-payment
- The difference in cost between the Generic Drug and the Brand Name Drug dispensed. The difference is not counted as a Covered Expense under **Medical Benefits.**] ⁵⁹¹

Non-Network Pharmacy

[There is no coverage for Prescription Drugs dispensed at a Non-Network Pharmacy.]⁵⁹²

[When a Non-Network Pharmacy is used, the Insured Person must pay for the entire cost of each prescription at the time it is filled. Then the Insured Person must submit a claim. Benefits are payable at the predominant contracted reimbursement rate (including any sales tax) for Network Pharmacies minus the applicable Co-payment.]⁵⁹³

[When a Non-Network Pharmacy is used, the Insured Person must pay for the entire cost of each prescription at the time it is filled. Then the Insured Person must submit a claim. Benefits are payable {at the Non-Network level}⁵⁹⁴ under Medical Benefits.]⁵⁹⁵

MEDICAL BENEFITS

(Continued)

PRESCRIPTION DRUG BENEFITS

(Continued)

[Mail Service Network Pharmacy

A mail service pharmacy option has been provided for convenience. If the mail service is used, the Insured Person must pay the Co-payment.

There is no covered for Prescription Drugs dispensed by a Non-Network Mail Service Pharmacy.

Mail service pharmacies dispense Generic Drugs whenever possible.

For Generic Drugs, an Insured Person pays the Mail Service Generic Drug Co-payment.]⁵⁹⁶

[An Insured Person pays the Mail Service Brand Name Drug Co-payment for Brand Name Drugs dispensed under either of the following conditions:

- There is no equivalent Generic Drug for substitution.
- The Physician orders a Brand Name Drug. This is usually done by writing "Dispense as written" on the prescription.]⁵⁹⁷

[For Brand Name Drugs which do not have a Generic Drug equivalent, an Insured Person pays the Mail Service Brand Name Drug Co-payment.]⁵⁹⁸

[For all other Brand Name Drugs, an Insured Person must pay:

- The Mail Service Generic Drug Co-payment.
- The difference in cost between the Generic Drug and the Brand Name Drug. The difference is not counted as a Covered Expense under **Medical Benefits.**] ⁵⁹⁹

Supply Limits

Retail Pharmacy

If the Prescription Drug is dispensed by a retail Pharmacy, the following limits apply:

- [Up to a {31-day }⁶⁰⁰ supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size. Some products may be subject to additional supply limits adopted by the Insurance Company. A list of current additional supply limits may be obtained from the Insurance Company. Up to {three - six – twelve}⁶⁰¹ cycles can be purchased at one time if a Co-payment is paid for each cycle supplied. [Insurer approval required prior to purchase of a twelve cycle supply.]⁶⁰²]⁶⁰³
- [A one cycle supply of an oral contraceptive. Up to {three - six – twelve}⁶⁰⁴ cycles can be purchased at one time if a Co-payment is paid for each cycle supplied.]⁶⁰⁵

[Mail Service Pharmacy

If the Prescription Drug is dispensed by a mail service pharmacy, the supply limit is up to a 90 day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size or any additional supply limits adopted by the Insurance Company. A list of current supply limits may be obtained from the Insurance Company.]⁶⁰⁶

Identification Card

If an Insured Person does not show the identification card at the time Prescription Drugs are obtained, the Insured Person will be required to pay the full cost of the Prescription Drug and received payment from the Insurance Company. In that case, benefits are calculated at the predominant contract reimbursement rate for a Network Pharmacy (including any sales tax), less the applicable Co-payment.

**MEDICAL BENEFITS
(Continued)**

**PRESCRIPTION DRUG BENEFITS
(Continued)**

Exclusions and Limitations

In addition to the provisions of the Policy titled "Medical Exclusions" and "General Limitations, the following will apply to Prescription Drug Benefits:

No Prescription Drug Benefits are payable for:

- [Drugs for Infertility treatment;]⁶⁰⁷
- [Drugs given while Confined in a Hospital, nursing home or similar place that has its own drug dispensary]⁶⁰⁸
- [Therapeutic devices or appliances, including colostomy supplies and support garments, regardless of intended use. (This exclusion does not apply to insulin syringes with needles, blood testing strips - glucose, urine testing strips - glucose, ketone testing strips and tablets, lancets and lancet devices which are covered.)]⁶⁰⁹
- [Injectable drugs (This exclusion does not apply to insulin or self-administered injectables which can be injected subcutaneously which are covered.);]⁶¹⁰
- [Progesterone suppositories;]⁶¹¹
- [Appetite suppressants and other weight loss products;]⁶¹²
- [General and injectable vitamins (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered.);]⁶¹³
- [Drugs dispensed in any amount which exceed the supply limits;]⁶¹⁴
- [Replacement drugs resulting from a lost, stolen, broken or destroyed Prescription Order or Refill;]⁶¹⁵
- [Unit dose packaging of drugs;]⁶¹⁶
- [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug;]⁶¹⁷
- [Contraceptive drugs or devices, when ordered for contraceptive purposes;]⁶¹⁸
- [Drugs for tobacco dependency or smoking cessation]⁶¹⁹.
- [Drugs for, or in connection with cosmetic surgery unless the Insured Person is injured as a result of an accident that occurs while he or she is covered for Medical Benefits under the Policy, which results in damage to his or her person requiring the cosmetic surgery;]⁶²⁰]⁶²¹

Extension of Medical Benefits.

Covered Medical Expenses incurred after termination of an Insured Person's Medical Benefits will be considered Covered Medical Expenses incurred while that insurance is in force, provided: (a) they are incurred prior to the end of the {three - twelve month}⁶²² period immediately following the date on which that insurance terminated; and (b) they result either from an Injury or a Sickness which causes the Insured Person to be Totally Disabled continuously from the day his or her insurance terminates until the day the Covered Medical Expenses are incurred.

However, the Extension of Medical Benefits will cease to apply to a person as of the date he or she becomes insured for medical care benefits provided under another group insurance plan or under any other arrangement of coverage for individuals in a group.

MEDICAL BENEFITS
(Continued)

Medical Exclusions

Covered Medical Expenses will not include, and no payment will be made for expenses incurred:

- [1. for services or supplies to the extent that benefits are available for the services or supplies elsewhere under the Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the {Participating Employer, Policyholder} contributes or makes payroll deductions whether or not an Insured Person is covered for such benefits;]⁶²³
- [2. for services or supplies for which benefits are not payable because of deductible or co-payment provisions under the Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the {Participating Employer, Policyholder}] contributes or makes payroll deductions;]⁶²⁴
- [3. for, or in connection with cosmetic surgery unless the Insured Person is injured as a result of an accident that occurs while he or she is covered for Medical Benefits under the Policy, which results in damage to his or her person requiring the cosmetic surgery;]⁶²⁵
- [4. for {eyeglasses, hearing aids}⁶²⁶ or examinations for prescription or fitting of {eyeglasses, hearing aids}⁶²⁷ unless specifically provided for elsewhere in the Policy; including any surgical procedures which are done primarily to correct a {refractive error, hearing loss}⁶²⁸.]⁶²⁹
1. [for, or in connection with treatment of the teeth or gums unless such expenses are incurred for (a) charges made for or in connection with dental work necessitated by Accidental Injury to natural teeth sustained while the Insured Person is covered for Medical Benefits under the Policy for services provided within {90 days}⁶³⁰ of the accident, or (b) charges made by a Hospital for Room and Board or Miscellaneous Services and Supplies;]⁶³¹
2. [Charges for Oral Contraceptives Drugs or Devices used primarily to prevent Pregnancy;]⁶³²
- [7. for which benefits are not payable according to the section of the Policy entitled General Limitations.]⁶³³

[Pre-existing Condition Limitation [For Late Entrants Only]]⁶³⁴

A Pre-existing Condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received within {six months}⁶³⁵ preceding of a person's effective date. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from a Physician.

A Covered Person shall not be entitled to payment for Covered Services performed in connection with a Pre-existing Condition for the first twelve (12) months, this or a prior carrier Contract providing payment for such Covered Services has been in effect without interruption.

With respect to a Pre-existing Condition:

no benefits are payable for a expenses incurred for an elimination period of twelve months beginning with the first day of any required Waiting Period under the Policy. This limitation will not apply to Pregnancy, to a newborn child or to a newly adopted child under age 18. [Any period of Creditable Coverage under a prior plan will be subtracted from the twelve month elimination period. However, if there has been a period of 63 days between the date coverage ended under such prior plan and the first day of any required Waiting Period under the Policy, any period of Creditable Coverage under such prior plan will *not* be subtracted from the twelve month elimination period.]⁶³⁶]⁶³⁷

[DENTAL BENEFITS

Dental Benefits are payable for Covered Dental Expenses incurred by an Insured Person.

Dental Benefits are determined this way:

1. subtract any Dental Deductible from Covered Dental Expense; and
2. multiply the result by the Percentage Payable.

Dental Deductible(s)

Individual Dental Deductible

The Individual Dental Deductible applies to each Insured Person. It is a dollar amount of Covered Dental Expense that must be met once each calendar year before benefits are payable for Dental Services.

[Family Dental Deductible

If the sum of Covered Dental Expenses used toward an Employee's and his or her Dependents' individual Dental Deductibles in a calendar year equals the Family Dental Deductible, the Individual Dental Deductible will be deemed to be met with respect to Covered Dental Expenses incurred by all Insured Persons in that family for the rest of that calendar year.]⁶³⁸

The Individual Dental Deductible [and the Family Dental Deductible]⁶³⁹ are shown in the Schedule of Benefits.

[CREDIT FOR DENTAL DEDUCTIBLE(S). Covered Dental Expenses which were applied toward the Dental Deductible(s) during the last three months of a calendar year will be applied to the Dental Deductible(s) of the next calendar year.]⁶⁴⁰

Percentage Payable

Dental Benefits are paid at percentages of Covered Dental Expenses incurred. These percentages are called the "Percentage Payable". Where the Percentage Payable is less than 100%, the Insured Person is responsible for the difference. The Percentage Payable is shown in the Schedule of Benefits.

Covered Dental Expenses

Covered Dental Expenses are the Reasonable and Customary Charges for Dental Services. This amount will not exceed the actual charge. Covered Dental Expenses must be incurred while insured. Dental Services means those services listed in Parts I, II or III of the Schedule of Dental Services. Such services must be done by or under the direction of a Dentist and must be: (a) required for the treatment or management of the dental condition; (b) commonly and customarily recognized by Dentists as appropriate in the treatment or management of the dental condition (as determined by the ADA or other recognized dental boards); (c) other than educational or experimental; (d) not primarily for the comfort or convenience of the Dentist or Insured Person; and (e) given in the most cost efficient setting consistent with maintaining high quality care.

Date Incurred

The date Covered Dental Expenses are incurred will be:

1. for full or partial dentures, on the date the final impression is taken;
2. for fixed bridges, crowns, inlays and onlays, on the date the teeth are first prepared;
3. for root canal therapy, on the later of: (a) the date the pulp chamber is opened; or (b) the date the canals are explored to the apex;
4. for periodontal surgery, on the date the surgery is actually performed;
5. for all other services, on the date the service is performed.

**DENTAL BENEFITS
(Continued)**

Calendar Year Maximum Benefit

The Calendar Year Maximum Benefit is the total of benefits payable for Covered Dental Expense incurred by an Insured Person in a calendar year. It is shown in the Schedule of Benefits

Late Entrants

Dental Benefits for an Insured Person who is a Late Entrant will be limited to the following:

- (1) [Only Part I services during the first six months the person is covered; and]⁶⁴¹
- (2) [Only Part I and Part II services during the second six months the person is covered.]⁶⁴²

If an Insured Person who is a Late Entrant suffers a Covered Dental Injury more than 90 days after becoming covered under this plan, benefits will be payable for Covered Dental Expenses incurred as a result of such Injury, as if the person were not a Late Entrant.

Schedule of Dental Services

The following is a list of Dental Services that will be considered for payment.

A temporary Dental Service will be considered a part of the final Dental Service.

**SCHEDULE OF DENTAL SERVICES
PART I - PREVENTIVE**

PROCEDURE

LIMITATIONS

[Oral Examination	Limited to twice in any one year period.
Emergency Oral Examination	
Complete Mouth Survey or Panoramic X-ray	Limited to once in any three year period. Includes bitewings and 10 to 14 periapical X-rays.
Individual Periapical X-rays	
Occlusal X-rays	Limited to once in any one year period
Extraoral X-rays	Limited to once in any one year period
Bitewing X-rays	Limited to twice in any one year period.
Other X-rays	
Bacteriologic Cultures	
Dental Prophylaxis	Limited to twice in any one year period.
Fluoride Treatments	Limited to twice in any one year period. Limited to children under the age of 16.] ⁶⁴³

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART I - PREVENTIVE
(Continued)**

[Space Maintainers	Limited to children under the age of 16.
Biopsy	
Palliative Treatment	Paid as a separate benefit only if no other service is rendered during the visit, except X-rays.
Application of Sealants	Limited to one application per tooth in any three year period and only for the first and second permanent molars of Insured Dependent Children under 15 years of age.] ⁶⁴⁴

**SCHEDULE OF DENTAL SERVICES
PART II - BASIC**

PROCEDURE

LIMITATIONS

[Diagnostic Casts	Limited to once in any three year period.
Amalgam Restorations	Multiple restorations on one surface will be paid as a single filling.
Pin Retention	Covered only in conjunction with an amalgam or composite restoration.
Silicate Restorations	
Plastic Restorations	
Composite Restorations	Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.
Re-Cement Inlays	
Re-Cement Crowns	
Crown Build-up	Covered only for endodontically treated teeth which require crowns.
Pulpotomy	
Root Canal Therapy	
Apicoectomy and Retrograde	Paid as a separate benefit only if Filling performed more than 12 months after the root canal therapy is completed.
Hemisection	
Provisional Splinting] ⁶⁴⁵	

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART II - BASIC
(Continued)**

PROCEDURE

LIMITATIONS

[Occlusal Adjustment	Covered only when performed with Periodontal Surgery or TMJ treatment.
Scaling and Root Planing	Limited to two times per quadrant of the mouth in any one year period.
Periodontal Prophylaxis	Limited to a combined maximum of one prophylaxis in any six consecutive month period including prophylaxis and periodontal prophylaxis.
Relining Dentures	Limited to relining done more than 12 months after the initial insertion, and then not more than once in any two year period.
Tissue Conditioning	
Repairs to Full Dentures, Partial Dentures, and Bridges	Limited to repairs or adjustments performed more than 12 months after the initial insertion.
Repairs to Crowns	
Re-Cement Bridges	
Simple Extraction	
Surgical Extraction Including Extraction of Impacted Teeth	
Root Recovery	
Excision of Pericoronal Tissues	
Incision and Drainage	
General Anesthesia	Will be paid as a separate benefit only when required for complex oral surgical procedures, provided such procedures are otherwise covered under the Policy.
Therapeutic Drug Injections] ⁶⁴⁶	

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART III - MAJOR**

All benefits for the services listed below include an allowance for all temporary restorations and appliances.

PROCEDURE

LIMITATIONS

[Gold Inlays and Onlays

Covered only when the tooth cannot be restored by a filling, and then only if more than five years has elapsed since the last placement.

Porcelain Restorations

Crowns

Covered only when the tooth cannot be restored by a filling, and then only if more than five years has elapsed since the last placement. For Insured Persons under 16 years of age, benefits are limited to Plastic or Stainless Steel Crowns.

Stainless Steel Crowns

Covered only when the tooth cannot be restored by a filling.

Post and Core

Covered only for endodontically treated teeth requiring crowns.

Gingivectomy *

Gingival Curettage *

Mucogingival Surgery *

Osseous Surgery *

* Only one of these surgical procedures per area of the mouth is covered in any one year period.

Osseous Grafts

Pedicle Grafts

Free Soft Tissue Grafts

Vestibuloplasty

Periodontal Appliance

Limited to one appliance in any one year period.

Full Dentures

There are no additional benefits for overdentures or customized dentures.

Partial Dentures

A partial denture includes clasps, rests and teeth. There are no additional benefits for precision or semi-precision attachments.

Denture Adjustments

Only covered once in any one year period, and only if performed more than 12 months after the insertion of the denture.]⁶⁴⁷

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART III - MAJOR
(Continued)**

PROCEDURE

LIMITATIONS

[Fixed Bridges

Maryland Bridge

Tooth Re-Plantation

Tooth Transplantation

Alveoplasty

Stomatoplasty

Removal of Exostosis

Frenectomy (Frenulectomy)

Excision of Hyperplastic Tissue]⁶⁴⁸

DENTAL BENEFITS (Continued)

[Orthodontics Benefits

[Dental Benefits will also include orthodontics for *Insured Dependent Children up to age 19 only.*]⁶⁴⁹

Benefits for orthodontics are determined this way:

1. subtract any Orthodontic Deductible from Covered Orthodontic Expenses; and
2. multiply the result by the Percentage Payable for orthodontics.

Covered Orthodontic Expenses

Covered Orthodontic Expenses means the Reasonable and Customary Charges for the following services. This amount will not exceed the actual charge.

1. Cephalometric x-rays.
2. Tooth movement for periodontal purposes.
3. Surgical exposure of impacted teeth.
4. Orthodontic treatment.

Covered Orthodontic Expenses must be incurred while insured under the Policy. Covered Orthodontic Expenses does not include orthodontic expenses if the appliance or bands are inserted before the person becomes insured under the Policy.

Date Incurred

The date all Covered Orthodontic Expenses are incurred will be:

1. the date the bands are inserted;
2. the date the appliance is inserted;
3. the date a procedure is performed, if it's completed on the same day it was started.

Lifetime Orthodontic Maximum

The total amount payable for Covered Orthodontic Expenses during an Insured Person's lifetime will not exceed the Lifetime Orthodontic Maximum shown in the Schedule of Benefits.

Benefit Payments

An orthodontic treatment plan must be submitted to the Insurance Company before benefits are payable for Covered Orthodontic Expense. Total benefits for the course of treatment will then be determined and divided into monthly benefits as follows:

1. Single Charge Basis: If the orthodontic treatment plan does not show a separate charge for appliance insertion, each monthly benefit will be the total benefit pro-rated over the number of months in the treatment plan.
2. Itemized Charge Basis: If the orthodontic treatment plan includes a separate charge for appliance insertion, the benefit for the first month of treatment will not exceed 25% of the total benefit. Subsequent monthly benefits will then be the balance of the total benefit pro-rated over the number of months remaining in the treatment plan.

The Insurance Company will notify the Insured Person and his or her Dentist of the benefits payable.

DENTAL BENEFITS (Continued)

Orthodontics Benefits (continued)

Benefit Payments (continued)

The Insurance Company has the right to require additional information to determine benefits payable. This includes but is not limited to:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models;
4. completion of a questionnaire that will specify: (a) the degree of overjet, overbite, crowding, or open bite; (b) if teeth are impacted, in crossbite, or congenitally missing; (c) the length of treatment; and (d) the total charge for the treatment.

Late Entrants

A person who is a Late Entrant will not be eligible for Orthodontic Benefits for the first 24 consecutive months he or she is covered under the Policy.

[Benefits After Attainment of the Dependent Child Limiting Age

Benefits will continue to be payable for an Insured Person who attains the Dependent Child limiting age, provided:

1. the appliance or bands were inserted while the person was under the limiting age, and covered under the Policy; and
2. he or she otherwise remains eligible for coverage; and
3. orthodontic treatment continues.]⁶⁵⁰

[DENTAL EXCLUSIONS

Covered Dental Expenses will not include, and Dental Benefits will not be payable for, the following charges:

1. charges for crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
2. charges for procedures relating to the change of vertical dimension; restoration of occlusion; bite registration; bite analysis; or which are cosmetic in nature;
3. charges for initial placement of full dentures, partial dentures or bridges if it includes the replacement of teeth all of which were missing on the date the Insured Person became covered under this plan. This exception will not apply if the prosthesis replaces a functioning tooth that was removed while covered;
4. charges for replacement of bridges, partial dentures, full dentures, inlays and crowns unless on the date of the replacement: (a) the Insured Person has been covered under the Policy for at least 12 consecutive months; and (b) it has been at least five years since the bridge, denture, inlay or crown was first inserted. This exception will not apply if the replacement is made necessary by: (i) the removal of a functioning natural tooth; or (ii) Covered Dental Injury to sound natural teeth; provided the removal or Injury occurred during the 12 months preceding the replacement;
5. charges for replacement of bridges, partial dentures, full dentures, crowns or inlays if they can be repaired;
6. charges for implants and related services;
7. charges for orthodontic treatment unless otherwise provided in a section of the Policy entitled "Orthodontics Benefits";
8. charges for appointments which are broken or otherwise missed;
9. for which benefits are not payable according to the section of the Policy entitled "General Limitations".]⁶⁵¹

[VISION CARE BENEFITS

If an Insured Person incurs covered vision care expense, the following benefits are payable.

Covered Vision Care Expenses

Covered Vision Care Expenses are the Reasonable and Customary Charges for each of the services or supplies listed in the Schedule of Vision Care Services and Supplies. Benefits are payable up to the Maximum Allowance that applies to each service or supply. Such services or supplies must be rendered by or recommended and approved by an ophthalmologist or optometrist. The Schedule of Vision Care Services and Supplies and the Maximum Allowances are shown in the Schedule of Benefits.

Vision Care Exclusions

No benefits are payable for:

- [1. charges for more than {one examination in any 12 consecutive month}⁶⁵² period;]⁶⁵³
- [2. charges for more than {one pair of lenses in any 24 consecutive month}⁶⁵⁴ period;]⁶⁵⁵
- [3. charges for more than {one set of frames in any 24 consecutive month}⁶⁵⁶ period;]⁶⁵⁷
- [4. charges for sunglasses, unless prescribed to be worn at substantially all times;]⁶⁵⁸
- [5. charges for examinations required by an Employer in connection with employment;]⁶⁵⁹
- [6. charges for any item or service not listed in the Schedule of Vision Care Services and Supplies;]⁶⁶⁰
- [7. charges for services or supplies to the extent that benefits are payable for the services or supplies elsewhere under the Policy;]⁶⁶¹
- [8. charges for which benefits are not payable according to the section of the Policy entitled "General Limitations".]⁶⁶²
]⁶⁶³

[GENERAL LIMITATIONS

No benefits will be payable under the Policy for any of the following:

- [1. charges incurred for, or in connection with an Injury arising out of, or in the course of, any employment for wage or profit, including self-employment;]⁶⁶⁴
- [2. charges incurred for, or in connection with a Sickness for which Insured Person is entitled to benefits under any worker's compensation or similar law;]⁶⁶⁵
- [3. charges for care or treatment of any Sickness or Injury that results from [active participation in]⁶⁶⁶ war, declared or undeclared, or [active participation in]⁶⁶⁷ any act of war, or committing or attempting to commit an assault or felony or from any intentionally self-inflicted Injury;]⁶⁶⁸
- [4. charges incurred for treatment to the extent that payment under the Policy is prohibited by any law of the jurisdiction in which the Insured Person resides at the time the expenses are incurred;]⁶⁶⁹
- [5. charges which the Insured Person is not legally required to pay or for charges which would not have been made if no insurance coverage had existed;]⁶⁷⁰
- [6. charges for services and supplies which are in excess of the lesser of: (a) the Reasonable and Customary Charge; or (b) the actual charge;]⁶⁷¹
- [7. charges for services and supplies that are not Medically Necessary;]⁶⁷²
8. [charges for non-surgical treatment of Temporomandibular Joint Dysfunction;]⁶⁷³
- [9. charges for vitamins or food supplements or for experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances;]⁶⁷⁴
- [10. charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;]⁶⁷⁵
- [11. charges for treatment, services or supplies received in a Hospital owned and operated by any government;]⁶⁷⁶
- [12. charges for private duty nursing services in a Hospital or any other facility;]⁶⁷⁷
- [13. charges in connection with a change in gender;]⁶⁷⁸
- [14. charges incurred by an Insured Person as an organ donor;]⁶⁷⁹
- [15. charges incurred for, or in connection with Custodial Care, education or training;]⁶⁸⁰
- [16. to the extent that the Insured Person is reimbursed, entitled to reimbursement, or is in any way indemnified for those expenses by or through any public program. For the purpose of this paragraph, any individual who, at any time, was entitled to enroll in all or any portion of the medical care program under Title XVIII of the Social Security Act of 1965, as amended (Medicare) but who did not so enroll will be considered to be entitled to reimbursement in an amount equal to the amount to which he or she would have been entitled, if any, if he or she were so enrolled;]⁶⁸¹
- [17. charges for services rendered by a member of the Insured Person's Immediate Family;]⁶⁸²
- [18. charges incurred in connection with the Pregnancy of an Insured Dependent Child;]⁶⁸³
- [19. Charges incurred for the treatment of Acquired Immune Deficiency Syndrome (AIDS);]⁶⁸⁴

GENERAL LIMITATIONS
(Continued)

[20.charges for a surgical procedure that does not correct the condition of Infertility but is used to induce Pregnancy, such as in-vitro fertilization, artificial insemination or similar procedure;]⁶⁸⁵

[21.charges for reversal of a voluntary surgical sterilization (charges for voluntary surgical sterilizations are covered);]⁶⁸⁶

The provision above which indicates that no payment will be made for expenses incurred in connection with Injury arising out of, or in the course of any employment for wage or profit will not apply with respect to any partner, proprietor, or corporate officer who is not himself or herself covered under worker's compensation or similar law.

No payment will be made under the Policy for expenses incurred by an Insured Person to the extent that he or she is reimbursed, entitled to reimbursement or in any way indemnified for those expenses by any personal Injury protection benefits payable under the mandatory portion of any group or individual automobile insurance policy written under the "no-fault" insurance provisions of the law of any jurisdiction.]⁶⁸⁷

[COORDINATION OF BENEFITS

Applicability. This provision applies to all {vision, dental and medical}⁶⁸⁸ benefits under the Policy

This Coordination of Benefits (“COB”) provision applies to This Plan when an Insured Person has coverage under more than one Plan. “Plan” and “This Plan” are defined below under “Definitions.”

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the Section entitled “Effect on the Benefits of This Plan”.

Definitions

“Plan” means any of these which provides benefits or services for the Insured Person:

1. Group or group-type insurance contracts;
2. Group or group-type subscriber contracts;
3. Uninsured arrangements of group or group-type coverage;
4. Group or group-type coverage through health maintenance organizations and other prepayment, group practice and individual practice plans;
5. The medical benefits coverage in group, group-type and individual automobile “no-fault” and traditional automobile “fault” type contracts; and
6. Coverage under a governmental plan or coverage required or provided by law; but not including: (a) 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); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

However, a Plan does not include school accident-type coverage that covers grammar, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis.

“Group-type” refers to contracts or coverage’s that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts and coverage’s answering this description are included in the definition of a Plan whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, “franchise” or “blanket”).

Each contract or other arrangement for coverage described above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

“This Plan” means the Policy.

“Primary Plan/Secondary Plan”: The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the Insured Person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When there are more than two Plans covering the Insured Person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

“Allowable Expense” means a Medically Necessary, Reasonable and Customary item of expense when such item is covered at least in part by one or more Plans covering the Insured Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid.

“Claim Determination Period” means a calendar year. However, it does not include any part of that period of time during which an Insured Person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

COORDINATION OF BENEFITS (Continued)

Order of Benefit Determination Rules

General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules, described in the Section entitled "Rules" below, require that This Plan's benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The benefits of the Plan which covers the Insured Person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the Insured Person as a Dependent.

Birthday. The Plan which covers an Insured Person as a Dependent of a person whose date of birth occurs earlier in a calendar year will pay before the Plan which covers an Insured Person as a Dependent of a person whose date of birth occurs later in a calendar year; provided:

1. if the other Plan does not have this rule, its alternate rule will govern; and
2. in the case of an Insured Dependent Child of divorced or separated parents, the rule set forth in the section titled Divorce/Separation below will apply.

Divorce/Separation. If there is a court decree which establishes financial responsibility for medical, dental or other health care expenses of a child, the Plan which covers child as a Dependent of the parent so responsible will be determined before any other Plan; otherwise:

1. the benefits of the Plan which covers the child as a Dependent of the parent with custody will be determined before the Plan which covers the child as a Dependent of a stepparent or a parent without custody
2. the benefits of the Plan which covers the child as a Dependent of a stepparent will be determined before the Plan which covers the child as a Dependent of a parent without custody.

Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Insured Person for the longer term are determined before those of the Plan which covered that Insured Person for the shorter term, subject to the following exceptions:

Active/Inactive Employee. The benefits of a Plan which covers an Insured Person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers the Insured Person as a laid off or retired Employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage. If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in this order:

1. First, the benefits of a Plan covering the Insured Person as an Employee, member or subscriber;
2. Second, the benefits under the continuation coverage.

If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

COORDINATION OF BENEFITS (Continued)

Effect of Medicare

If the Insured Person is also a Medicare beneficiary:

1. due to end stage renal disease, This Plan will determine benefits without consideration of Medicare benefits for which the Insured Person is eligible during the first 30 months of his or her eligibility for such Medicare benefits; or
2. due to any other condition, or due to attainment of age 65 or 70, This Plan will determine benefits without consideration of Medicare benefits for which the Insured Person is eligible.

Effect on the Benefits of This Plan

When This Section Applies. This Section applies when, in accordance with the Section entitled "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Insurance Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Insurance Company any facts it needs to pay the claim.

Facility of Payment. A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the Insurance Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Insurance Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Insurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.]⁶⁸⁹

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Insurance Company within {30}⁶⁹⁰ days after the occurrence of the event on which the claim is based.

Written notice of claim given by or on behalf of the Insured Employee to the Insurance Company at its Home Office, or to any authorized agent of the Insurance Company, with particulars sufficient to identify the Employee, will be considered notice to the Insurance Company. Failure to give written notice within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as was reasonably possible.

Claim Forms. The Insurance Company, will furnish to person making claim or to the {Participating Employer, Policyholder} for delivery to such person, the claim forms which it usually furnishes for filing proofs of loss. If such forms are not furnished before the expiration of {15}⁶⁹¹ days after the Insurance Company receives notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proofs of Loss. Written proof of loss must be furnished to the Insurance Company at its Home Office within {365}⁶⁹² days after the date of the loss for which claim is made. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Insurance Company may reasonably require. Failure to furnish written proof of loss within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to furnish written proof of loss within that time and that written proof of loss was furnished as soon as was reasonably possible.

Time of Payment of Claims. All benefits payable under the Policy other than benefits for loss of time will be payable not more than {60}⁶⁹³ days after receipt of proof, and that, subject to proof of loss, all accrued benefits payable under the Policy for loss of time will be paid not less frequently than monthly during the continuance period for which the Insurance Company is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof.

Payment of Claims. Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Employee. If an Insured Employee dies before all payments due have been made, the amount still payable will be paid to his or her estate.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Insurance Company may make an initial payment, up to an amount not exceeding {\$5,000}⁶⁹⁴, to any relative by blood or connection by marriage of the payee who is deemed by the Insurance Company to be equitably entitled thereto. Such payment does not discharge the Insurance Company's liability for any remaining benefits payable under the Policy.

All or any portion of the Medical, Dental, or Vision Benefits provided by the Policy may, at the option of the Insurance Company, be paid directly to the individual or institution on whose charges claim is based or to any of the following surviving relatives of the Employee: wife, husband, mother, father, child or children, brothers or sisters; or to the executors or administrators of the Employee.

Any payment the Insurance Company makes in good faith fully discharges the Insurance Company's liability to the extent of the payment made.

Direct Payment of Hospital or Medical Services. All or any portion of any indemnities provided by the Policy on account of Hospital, nursing, medical or surgical services may, at the Insurance Company's option, be paid directly to the Hospital or person rendering such services, but the Policy may not require that the service be rendered by a particular Hospital or person. Payments so made shall discharge the Insurance Company's obligation with respect to the amount of insurance so paid.

GENERAL PROVISIONS

Legal Actions. No action at law or in equity will be brought to recover on the Policy prior to the expiration of {90} days after written proof of loss has been filed in accordance with the requirements of the Policy, nor will any action be brought at all unless brought within {three}⁶⁹⁵ years from the expiration of the time within which proof of loss is required by the Policy.

Time Limitations. If any time limitation provided in the Policy for giving notice of claims, for furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the jurisdiction in which the Employee resides at the time the Policy is issued, then the time limitation of the prevailing jurisdiction applies.

Physical Examination and Autopsy. The Insurance Company, at its own expense, will have the right and opportunity to examine any individual for whom claim is pending under the Policy when and as often as it may reasonably require and to make an autopsy in case of death where it is not forbidden by law.

Reimbursement and Subrogation. When an Insured Person's Injury appears to be someone else's fault, benefits otherwise payable under the Policy for covered expenses incurred as a result of that Injury will not be paid unless the Insured Person or his legal representative agrees:

1. to repay the Insurance Company for such benefits to the extent they are for losses for which compensation is paid to the Insured Person by or on behalf of the person at fault;
2. to allow the Insurance Company a lien on such compensation and to hold such compensation in trust for the Insurance Company; and
3. to execute and give to the Insurance Company any instruments needed to secure the rights under (a) and (b).

Further, when the Insurance Company has paid benefits to or on behalf of the injured Insured Person, the Insurance Company will be subrogated to all rights of recovery that the Insured Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Insurance Company has paid. The Insured Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Insurance Company.

Disclaimer: The Insurance Company is not a healthcare provider and therefore, cannot guarantee any results or outcomes of healthcare treatment you or your eligible dependents may receive or your failure to obtain medical treatment

NOTICE OF FEDERAL REQUIREMENTS

Coverage for Reconstructive Surgery Following Mastectomy

When a person who is insured for benefits under this Certificate and who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your Employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

[ERISA INFORMATION

This Employee Benefit Plan (the "Plan"), sponsored by {ABC Industries, Inc.}⁶⁹⁶ is intended to comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The following information, together with the information contained in this booklet complies with the Plan Administrator's ERISA disclosure obligations. This information is furnished by the Plan Administrator and is not a part of the Policy. The Policy may be obtained from the Plan Administrator or the Insurer by written request at the addresses listed below.

PLAN NAME: {Employee Benefit Plan}⁶⁹⁷

PLAN NUMBER: {000}⁶⁹⁸

PLAN SPONSOR/PLAN ADMINISTRATOR: [ABC Industries, Inc.
101 N. Main Street
Anytown, DE 19801]⁶⁹⁹

EMPLOYER IDENTIFICATION NUMBER (EIN):{XX-XXXXXX}⁷⁰⁰

PLAN TYPE: This booklet provides information about the Group {Life, Accidental Death and Dismemberment, Supplemental Life, Supplemental Accidental Death and Dismemberment, Long Term Disability, Medical, Dental, Vision}⁷⁰¹ Insurance for Employees covered under the Plan and {Dependent Life, Dependent Accidental Death and Dismemberment, Medical, Dental, Vision}⁷⁰² benefits for Employee's Dependents.

TYPE OF ADMINISTRATION: Insurer administration -
Delaware American Life Insurance Company
600 King Street
Wilmington, DE 19801

PLAN ADMINISTRATION:

The Plan is administered by the Plan Administrator which is the Named Fiduciary for the Plan. The Plan Administrator has discretionary authority to determine the status and rights of participants, beneficiaries and other persons, to construe and interpret Plan terms, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be sufficient to warrant deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire and Rubber Co. v. Bruch.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

ERISA INFORMATION
(Continued)

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Group {Life, [Accidental Death and Dismemberment, Supplemental Life, Supplemental Accidental Death and Dismemberment, Dependent Life, Dependent Accidental Death and Dismemberment, Long Term Disability, Medical, Dental, Vision]}⁷⁰³ Insurance benefits described in this benefit booklet are provided pursuant to an insurance contract issued to {ABC Industries, Inc.}⁷⁰⁴ by The Delaware American Life Insurance Company. Delaware American life Insurance Company is the Claims Administrator for these Group {Life, Accidental Death and Dismemberment, Supplemental Life, Supplemental Accidental Death and Dismemberment, Dependent Life, Dependent Accidental Death and Dismemberment, Long Term Disability, Medical, Dental, Vision}⁷⁰⁵ Insurance benefits. The Plan Administrator has delegated to Delaware American Life Insurance Company its entire discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the contract.

WAIVER:

Failure by the Plan or Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

GOVERNING LAW:

The Plan shall be interpreted under federal law, including ERISA, and by the laws of the State of Delaware, to the extent not preempted.

THE AGENT FOR SERVICE OF LEGAL PROCESS:

[ABC Industries, Inc.
101 N. Main Street
Anytown, DE 19801]⁷⁰⁶

SOURCE OF CONTRIBUTIONS:

{The Employer and Employees share in the cost of this Insurance.,The Employer pays the cost of this Insurance.}⁷⁰⁷

PLAN YEAR:

The fiscal records of the Plan are kept on a {Plan, Calendar}⁷⁰⁸ year basis, {July 1 through June 30}⁷⁰⁹.

ERISA INFORMATION
(Continued)

PLAN MODIFICATION, AMENDMENT AND TERMINATION:

The Insurance Company reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all provisions of the Plan, including termination of the Plan. Amendments to this Plan, or termination of this Plan, are to be made by a written resolution adopted in accordance with the established procedures of the Board of Directors. Amendments may be adopted with retroactive effect to the extent permitted by ERISA and the Code. Any change will affect all covered persons, including Dependents, retirees and disabled individuals.

CLAIM DENIALS AND APPEAL OF DENIED CLAIMS:

If a claim is denied in whole or in part, the covered person will receive a written notification within 90 days from the date the claim was submitted. If additional information is needed for consideration of the claim, the Insurer/Claims Administrator will request it from either the provider of the service or the covered person. If special circumstances warrant an extension of time, a written notice will contain an explanation of the special circumstances necessitating the extension. In no event shall the extension exceed a period of 90 days from the end of the initial period (i.e., 180 days from the date the claim was submitted). For all claims, an explanation of benefits form will be provided by the Insurer/Claims Administrator showing the calculation of the total amount payable, the charges not payable, and the reason for the denial of any charges not covered. If an explanation of why the benefits were denied is not received by the end of the 90 day period (or 180 days if an extension is requested), the claim should be deemed denied.

Any covered person may request a review of the denial of any benefit claim by submitting a written request for review to the Insurer/Claims Administrator. This must be done within 60 days after the denial is received by the covered person (or 60 days from the expiration of the period after which the claim is deemed denied).

Any covered person and/or his authorized representative may examine pertinent documents which the Plan Administrator has and submit opinions and comments. The decision of the Insurer/Claims Administrator regarding a request for a review of a denied claim will be in writing and will be made within 60 days of receiving a request for review of a denied claim, unless special circumstances require an extension of time. If special circumstances warrant an extension of time, a written notice of the extension will be sent prior to the expiration of the original 60 day period. Such notice shall contain an explanation of the special circumstances necessitating the extension. In no event shall the extension exceed a period of 60 days from the end of the initial period (i.e., 120 days from the date of the request for review).

The decision of the Insurer/Claims Administrator will be delivered to the covered person in writing and will set forth the specific reasons for the decision and specific references to pertinent provisions of the Plan on which the decision was based. If a written determination as to the request for review of the denied claim is not received by the end of the 60 day period (or 120 days if an extension is requested), the claim should be deemed denied on review. The decision on review of the Insurer/Claims Administrator will be final.

ERISA INFORMATION
(Continued)

PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Employer and any participant, nor to be consideration or an inducement for the employment of any participant or Employee. Nothing contained in this Plan shall be deemed to give any participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any participant or Employee at any time, subject to the terms of any applicable collective bargaining agreement, regardless of the effect which such discharge shall have upon him as a participant of this Plan.

STATEMENT OF ERISA RIGHTS:

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- (a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (b) Obtain copies of all documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the Plan's annual financial report. The Plan Administrator may be required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit or exercising your rights under ERISA. If your claim for a Welfare Benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquirers, Pension and Welfare Benefit Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.]⁷¹⁰

SERFF Tracking Number: DLAL-126475792 State: Arkansas
 Filing Company: Delaware American Life Insurance Company State Tracking Number: 45230
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Expat Policy Filing
 Project Name/Number: Expat Policy Filing/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	07/06/2010
Comments: See Form Schedule Tab		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	07/06/2010
Comments: Attachment: Delam Expat-APP.pdf		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	07/06/2010
Bypass Reason: N/A - Group Expat Medical		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	07/06/2010
Bypass Reason: N/A - Group Coverage		
Comments:		



DELAWARE AMERICAN LIFE INSURANCE COMPANY
 600 King Street
 WILMINGTON, DELAWARE 19801

GROUP INSURANCE APPLICATION

Application is hereby made to Delaware American Life Insurance Company, for a Group Insurance Plan providing the type(s) of insurance indicated below and in accordance with the specifications requested by:

 [ABC Company, Inc]
 Full Legal Name of [Policyholder] [Participating Employer]

 [15th Street and New York Avenue, Wilmington, DE 19801]
 Address of Applicant (including zip code)

Insurance to be provided: (check below)

	Employees Only	Employees and Dependents
Life Insurance	[x]	[x]
Accidental Death & Dismemberment Insurance	[x]	N/A
Vision Care Benefits	[x]	[x]
Dental Benefits	[x]	[x]
Medical Benefits	[x]	[x]
LTD Benefits	[x]	N/A

Effective Date: It is requested that the insurance be effective from 12:01 A.M., standard time at the [Policyholder's] [Participating Employer's] address on [March 1, 2006]. No insurance shall be effective until this application is accepted and the effective date approved by Delaware American Life Insurance Company and until a binder premium is paid. Insurance on a contributory basis shall not be effective until the date when the required percentage of the eligible employees has agreed to make the required contributions toward the premium for the insurance.

Dated at: _____ By: _____
 Signature of Company Representative

On: _____ Title: _____

 Witness

SERFF Tracking Number: DLAL-126475792 State: Arkansas
 Filing Company: Delaware American Life Insurance Company State Tracking Number: 45230
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Expat Policy Filing
 Project Name/Number: Expat Policy Filing/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/09/2010	Form	Expat Certificate MDV	06/15/2010	Delam Expat-cert M D V.pdf (Superseded)



**DELAWARE AMERICAN
LIFE INSURANCE COMPANY**

600 KING STREET, WILMINGTON, DELAWARE 19801
(302) 594-2000
(Herein called the Insurance Company)

[Policyholder: [ABC Company]]
[Participating Employer: [XYZ Employer, Inc]]
Policy Number: [G-0001]
Policy Effective Date: [Month XX, Year]
Anniversary Date: [Month XX]

GROUP INSURANCE POLICY

This Group Policy (herein called "the Policy") is a legal contract between the [Policyholder], [Participating Employer] and the Insurance Company. The Insurance Company agrees to insure eligible persons of the [Policyholder] [Participating Employer] (herein called Insured Person(s) against loss covered by this Policy subject to its provisions, limitations and exclusions. The persons eligible to be Insured Persons are all persons described in the Eligible Employee section of the Policy.

This Policy is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Master Application, which is attached to and made part of this Policy.

This Policy begins on the Policy Effective Date shown above and continues in effect as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid.

This Policy is governed by the laws of the state of Delaware. It is the intent of this policy to cover only employees who are working outside their country of permanent residence.

The President and Secretary of Delaware American Life Insurance Company witness this Policy:

President

Secretary

Registrar

PLEASE READ THIS POLICY CAREFULLY.

Non-Participating Policy

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[PARTICIPATING EMPLOYERS

An Employer may be included as a Participant Employer if the Policyholder and the Insurance Company so agree.

The Insurance Company will keep a list of accepted Participating Employers and the effective date of coverage for each.

The Policyholder may act for or on behalf of all Participating Employers in all matters of this Policy. The following will be binding on all Participating Employers:

- (1) all agreements between the Insurance Company and the Policyholder;
- (2) all notices from the Insurance Company to the Policyholder; and
- (3) all notices from the Policyholder to the Insurance Company.

An Employee of a Participating Employer will be deemed to be an Employee of the Policyholder for insurance purposes.

Coverage for a Participating Employer will terminate on the first of the following to occur:

- (1) the date premium is due, but not paid; or
- (2) the date on which the Policyholder wants the Employer to be removed from this Policy. Such date must be stated in a written notice to the Insurance Company, and must be after the date of the notice.]

INCORPORATION PROVISION

Certificate

The Certificate attached to this Policy is hereby incorporated in, and made a part of, this Policy.

The terms found in the certificate will control:

- (1) the benefit plan provisions;
- (2) the eligibility and effective date of insurance rules;
- (3) the termination of insurance rules;
- (4) exclusions; and
- (5) other general policy provisions pertaining to state insurance law requirements.

SCHEDULE OF BENEFITS

Schedule of Benefits

The Schedule of Benefits for this Policy is shown in the Certificate.

The Schedule of Benefits will control the:

- (1) benefit amounts and maximum limits;
- (2) applicable coinsurance percentages;
- (3) eligibility and effective date rules; and
- (4) other schedule amounts and limits,

which apply to the covered Employees of the [Policyholder] [Participating Employer].

PREMIUMS

Payment of Premiums. The initial premium will be due on the effective date to cover the period from that date to the first premium due date which is one month or more after the effective date. Premiums thereafter will be due on each succeeding premium due date. Premiums are payable at the home office of the Insurance Company.

Premium Rate. The premium will be determined on the basis of the rates set forth below. [All amounts are U.S. dollars.]

COVERAGE TYPE	MONTHLY RATE

The Insurance Company has the right, on any premium due date, to change the premium rates for the insurance under the Policy.

Payment of Premium. All premiums are payable by the [Participating Employer] [Policyholder] at the Home Office of the Insurance Company on or before the date on which they fall due. The first premium is due on the [Participating Employer's] [Policyholder's] effective date of coverage under the Policy. Each premium due after the first must be paid on or before the first day of each month after the first premium is paid. If a premium is not paid on or before its due date, the Policy, subject to the Grace Period, will be in default. A change in premium due to a change in insurance in force will become due on the next premium due date after the change. Each premium will include any adjustment in past premiums which is caused by those changes which have not been taken into account at a prior date.

Grace Period. The [Policyholder] [Participating Employer] is entitled to a Grace Period of 31 days for the payment of premium due except the first, during which Grace Period the coverage shall continue in force, unless the [Policyholder] [Participating Employer] shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy.

POLICY PROVISIONS

Contract. The Policy and the application of the [Policyholder] [Participating Employer], and any applications of the Employees, will constitute the entire contract between the parties. All statements made by a [Policyholder] [Participating Employer] or by an Insured Employee will, in the absence of fraud, be considered representations and not warranties, and no statement made for the purpose of obtaining insurance will be used in any contest to void the insurance or reduce the benefits provided by the Policy unless contained in a written instrument signed by the [Policyholder] [Participating Employer] or the Insured Employee, a copy of which is or has been furnished to the [Policyholder] [Participating Employer] or to the Insured Employee or to his or her beneficiary.

No change in the Policy will be valid unless approved by the Insurance Company and evidenced by endorsement on the Policy or by amendment to the Policy signed by the [Policyholder] [Participating Employer] and by the Insurance Company acting through its President, Vice President, Secretary, Assistant Secretary or Registrar. No agent has authority to change the Policy or to waive any of its provisions. The validity of any change in the Policy will not be affected by the failure to obtain the consent of any Employee.

Incontestability. The validity of the Policy shall not be contested except for non-payment of premium, after it has been in force for two years from the Policy Effective Date; no statement made by any Insured Person under the Policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her; provided however, that no such provision shall preclude the assertion at any time of defenses based upon provisions in the policy which relate to eligibility for coverage.

Certificates. The Insurance Company will issue, to each [Participating Employer] [Policyholder] for delivery to each Insured Employee, a certificate which describes an Insured Person's coverage, to which benefits will be paid and any rights and conditions as set forth in the Policy.

Misstatement of Age. If the age, of the Insured Employee were not accurate in the application to the Policy:

1. a fair adjustment of premium will be made; and
2. the true age will decide whether and in what amount of insurance is in force under the Policy.

Workers' Compensation. This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. A purely clerical error, which arises from other than a failure to perform administrative duties hereunder, whether by [the Policyholder] [the Participating Employer] or the Insurance Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect; nor will it extend insurance of such person if that insurance would otherwise have ended or been reduced as provided in the Policy. Clerical error may be, by illustration but not limitation, errors in transcription or computation, but is not, by illustration but not limitation, a failure to advise Insured Persons of procedural requirements.

Insurance Data. The [Participating Employer] [Policyholder] will furnish the Insurance Company with all the data necessary for the calculation of the premium and all other data that may reasonably be required by the Insurance Company. Failure on the part of the [Participating Employer] [Policyholder] to furnish the necessary data will neither invalidate any Employee's insurance nor continue any Employee's insurance beyond the date of termination determined in accordance with the section entitled "Termination of Insurance".

Agency. For the purposes of the Policy, each [Participating Employer] [Policyholder] acts on its own behalf or as the agent of the Insured Person. Under no circumstances will any [Participating Employer] [Policyholder] be deemed the agent of the Insurance Company without written authorization.

Whenever coverage provided by this policy would be in violation of United States' economic or trade sanctions, such coverage shall be null and void.

POLICY TERMINATION DATES AND RENEWAL WITH ALTERED TERMS

Policy Termination by the Insurance Company. Except for non-payment of premium, the Insurance Company may not terminate the [Participating Employer's] [Policyholder's] coverage under the Policy prior to the [Participating Employer's] [Policyholder's] first anniversary date of coverage under the Policy. The Insurance Company may terminate the [Participating Employer's] [Policyholder's] coverage under the Policy by mailing or delivering to the [Participating Employer] [Policyholder], written notice [60] days in advance. Termination will take effect at 12:01 a.m. Standard Time at the [Participating Employer's] [Policyholder's] address on the date of termination. The Insurance Company may terminate the [Participating Employer's] [Policyholder's] coverage under the Policy on any premium due date, if on such date:

1. there are fewer than [10] Insured Employees of a [Participating Employer] [Policyholder] covered under the Policy;
2. less than 100% of the persons eligible for Non-Contributory insurance under the [Participating Employer's] [Policyholder's] coverage under the Policy are covered under the Policy;
3. less than [75]% of the persons eligible for Contributory insurance under the [Participating Employer's] [Policyholder's] coverage under the Policy are covered under the Policy;
4. the [Participating Employer] [Policyholder] fails to promptly furnish any information which the Insurance Company may reasonably require;
5. the [Participating Employer] [Policyholder], without cause, fails to perform its duties relating to the Policy in good faith.

The [Participating Employer's] [Policyholder's] coverage under the Policy may also be terminated at any time by the mutual written consent of the [Participating Employer] [Policyholder] and the Insurance Company.

Termination will not affect coverage for which premium has been paid, but the Insurance Company will not accept any additional premium after coverage under the Policy terminates.

Policy Termination for Non-Payment of Premium. If any premium is not paid by the end of the Grace Period, the [Participating Employer's] [Policyholder's] coverage under the Policy will terminate in accordance with the provisions of the paragraph entitled "Grace Period".

Policy Re-rating for Change in [Participating Employer] [Policyholder] Demographics. If at any point after the first Policy Anniversary there is a change in total demographics, that is, an increase or decrease of more than 20% since the initial rating or last renewal, the Company has the option of re-rating the policy.

Policy Termination by the [Participating Employer] [Policyholder]. The [Participating Employer] [Policyholder] may terminate coverage under the Policy by mailing or delivering to the Insurance Company written notice at least [31] days in advance of any premium due date. Termination will take effect at 12:01 a.m. Standard Time at the [Participating Employer's] [Policyholder's] address on the termination date specified in such notice.

Policy Renewal With Altered Terms. If, on an anniversary date of the [Participating Employer's] [Policyholder's] coverage under the Policy, the [Participating Employer's] [Policyholder's] coverage under the Policy is to be renewed with terms less favorable to the [Participating Employer] [Policyholder] or at an increased premium, the Insurance Company will give the [Participating Employer] [Policyholder] [60] days notice of such change and/or premium rate increase as well as notice of the [Participating Employer's] [Policyholder's] right not to renew the Policy

If such notice is not sent to the [Participating Employer] [Policyholder] [60] days prior to such anniversary date, the changes will not be effective until [60] days after such notification is sent to the [Participating Employer] [Policyholder]. During the [60]-day period, the [Participating Employer] [Policyholder] may terminate coverage under the Policy. In the event of such termination, the Insurance Company will return any unearned premium based on the previous year's premium rates.

If no notice is given to the [Participating Employer] [Policyholder] by the Insurance Company, the [Participating Employer's] [Policyholder's] coverage under the Policy will be renewed for: (a) an additional policy term, if the original policy term was less than one year; or (b) one year, if the original policy term was one year or more.

**POLICY TERMINATION DATES
AND RENEWAL WITH ALTERED TERMS
(continued)**

However, this provision will not apply if the change to the [Participating Employer's] [Policyholder's] coverage under the Policy on renewal is a premium increase which is either: (a) less than [25%] and is generally applicable to the Insurance Company's group insurance policies; or (b) the result of an action or actions by the [Participating Employer] [Policyholder] which alters the nature or extent of the risk. The consent of an Employee or other person referred to in the Policy is not required to terminate, amend, modify or change the Policy.



**DELAWARE AMERICAN LIFE
INSURANCE COMPANY**

Policyholder: [ABC Incorporated]
[Participating Employer: [XYZ Employer, Inc]]
Policy Number: [XXXXXX]

600 King Street
WILMINGTON, DELAWARE 19801
(302) 594-2000
(Herein called the Insurance Company)

GROUP INSURANCE CERTIFICATE RIDER NO.

This Rider is attached to and made part of the Certificate [as of the Policy Effective Date shown in the Policy] [effective [Month Day, Year].] It applies only with respect to covered losses that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider.

Certificate for Policy XXXXX

In consideration of timely payment of the required premium, the Certificate is amended as follows:

The President and Secretary of Delaware American Life Insurance Company witness this Rider.

President

Secretary



DELAWARE AMERICAN LIFE INSURANCE COMPANY
 600 King Street
 WILMINGTON, DELAWARE 19801

GROUP INSURANCE APPLICATION

Application is hereby made to Delaware American Life Insurance Company, for a Group Insurance Plan providing the type(s) of insurance indicated below and in accordance with the specifications requested by:

_____ [ABC Company, Inc] _____
 Full Legal Name of [Policyholder] [Participating Employer]

_____ [15th Street and New York Avenue, Wilmington, DE 19801] _____
 Address of Applicant (including zip code)

Insurance to be provided: (check below)

	Employees Only	Employees and Dependents
Life Insurance	[x]	[x]
Accidental Death & Dismemberment Insurance	[x]	N/A
Vision Care Benefits	[x]	[x]
Dental Benefits	[x]	[x]
Medical Benefits	[x]	[x]
LTD Benefits	[x]	N/A

Effective Date: It is requested that the insurance be effective from 12:01 A.M., standard time at the [Policyholder's] [Participating Employer's] address on [March 1, 2006]. No insurance shall be effective until this application is accepted and the effective date approved by Delaware American Life Insurance Company and until a binder premium is paid. Insurance on a contributory basis shall not be effective until the date when the required percentage of the eligible employees has agreed to make the required contributions toward the premium for the insurance.

Dated at: _____ By: _____
 Signature of Company Representative

On: _____ Title: _____

 Witness



DELAWARE AMERICAN LIFE INSURANCE COMPANY

ONE ALICO PLAZA
WILMINGTON, DELAWARE 19801
(302) 594-2000
(Herein called the Insurance Company)

CERTIFICATE OF INSURANCE

for certain Employees of:

[XYZ NIGERIA]

([a Participating Employer] effective [August 1, 2006])

who are insured under Group Policy Number [xxxx]
issued to

[ABC Company]
(the Policyholder)

Delaware American Life Insurance Company hereby certifies that certain benefits provided by the Group Policy are available to Employees of the [Participating Employer] [Policyholder] who are in an Eligible Class. Under no circumstances may any insurance become effective prior to the Effective Date as determined in the section of this document entitled Effective Date of Insurance.

INTRODUCTION

ABOUT THIS CERTIFICATE. This Certificate describes group life [and accident] insurance the Insurance Company provides to Insured Persons under the Group Policy (herein called "the Policy") issued to the Policyholder.

This document describes the coverage available under the Policy. It becomes an Employee's Certificate of Insurance only after he or she has met the eligibility requirements set forth in the section of this document entitled Eligibility for Insurance.

The coverage is funded through a Group Policy issued to the Policyholder by Delaware American Life Insurance Company.

The terms of the Policy that affect your insurance are contained in the following pages.

This Certificate of Insurance and the following pages will become your Certificate. This Certificate is a part of the Policy.

This Certificate replaces any other that the Company may have issued to the [Policyholder] [Participant Employer] to give to you under the Policy specified herein.

The President and Secretary of Delaware American Life Insurance Company witness this Certificate:

President

Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

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SCHEDULE OF BENEFITS

Eligible Employees: [All active, full-time [[US] Expatriate], [Third Country National] and [Key Local National] Employees of the Employer who normally work at least [30 hours per week.]]

[Note: [This plan covers only Employees [and their dependents] residing in the [country, countries] of [United Kingdom].] [The plan does not cover any Employees [and their dependents] residing in the [country, countries] of [Iraq].] [Any Employees [and their dependents] who return to the U.S.A. for more than [90 continuous days] will be terminated under the plan.]

Waiting Period

[Life	[None]]
[AD&D:.....	[None]]
[All Benefits:.....	[None]]

[[Open] [Annual] Enrollment Period: [November 1 of each succeeding year]
[Open Enrollment Effective Date: [January 1 following the Open Enrollment Period]]]

[[BASIC] [VOLUNTARY] LIFE INSURANCE

<u>Classification</u>	<u>Maximum Amount</u>
[All Eligible Employees	[One times basic annual salary to a maximum of \$200,000]]

[SUPPLEMENTAL LIFE INSURANCE

<u>Classification</u>	<u>Maximum Amount</u>
[All Eligible Employees	[One time, two times or three times basic annual salary.]]

[SURVIVOR INCOME PROTECTION

<u>Classification</u>	<u>Maximum Amount</u>
[All Eligible Employees	[One times, two times or three times basic annual salary payable in either 12 or 24 or 36 monthly installments respectively.]]

[However, in no event may the total amount of Life Insurance in force with respect to any one Insured Employee exceed [\$1,000,000.]]

[DEPENDENT LIFE INSURANCE

<u>Classification</u>	<u>Maximum Amount</u>
Dependent Spouse	[\$25,000]
Dependent Children	
[14] days to [19] years	
(Age [23] if a full-time student)	[\$ 500]]

[Guaranteed Issue Amount

The Guaranteed Issue Amount for [Basic] [Voluntary] [, Supplemental] [, Survivor Income Protection] [and] [Dependent] Life Insurance is [\$100,000] [for an Insured Employee] [and] [\$25,000] [for an Insured Spouse]. Any amount of Life Insurance in excess of the Guarantee Issue Amount is subject to Evidence of Insurability.]

**SCHEDULE OF BENEFITS
(Continued)**

[ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

<u>Classification</u>	<u>Principal Sum</u>
[All Eligible Employees	[One] times basic annual salary to a maximum of \$200,000]]

[SUPPLEMENTAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

<u>Classification</u>	<u>Principal Sum</u>
[All Eligible Employees	Choice[One or Two or Three] times basic annual salary to a maximum of \$200,000]]]

[Reduction of Life [and] [Accidental Death and Dismemberment] Insurance

[All amounts reduce by [35%] at age [65] and by an additional [15%] at age [70].]]

DEFINITIONS

["Accidental Injury"] means bodily Injury caused by an accident occurring while the Policy is in force with respect to the person whose Injury is the basis of a claim and resulting directly and independently of all other causes in a covered loss under the Policy. This includes related conditions and recurrent symptoms of such Injury.]

["Acquired Immune Deficiency Syndrome"] (AIDS) shall have the meanings assigned to it by the World Health Organization. The term opportunistic infection shall include but not be limited to Pneumocystis carini pneumonia, organism of chronic enteritis, virus and/or disseminated fungi infection. The term malignant neoplasm shall include but not be limited to Karposi's sarcoma, central nervous system lymphoma and/or other malignancies now known or which become known as immediate causes of death in the presence of acquired immune deficiency. Acquired Immune Deficiency Syndrome shall include H.I.V. (Human Immune Deficiency Virus), encephalopathy (dementia) and H.I.V. (Human Immune Deficiency Virus) wasting syndrome.]

["Active Service"] An Employee will be considered in Active Service if he or she is performing in the customary manner all of the regular duties of his or her employment on a regularly scheduled work day at his or her usual place of employment or at some location to which the [Participating Employer's] [Policyholder's] business requires him or her to travel. An Employee will be considered in Active Service on a regularly scheduled non-work day if he or she was in Active Service on the immediately preceding scheduled work day.

["Automobile"] means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.]

["Basic Earnings"] means the Insured's basic rate of pay received from his or her Employer, or primary income received from his or her primary occupation. [It does not include overtime, bonus or any other form of additional compensation.]]

["Certificate"] means a written statement prepared by the Insurance Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an Employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

["Classification"] or **["Earnings"]** mean an Employee's Classification or Earnings as reported to the Insurance Company by the [Participating Employer] [Policyholder]. The [Participating Employer's] [Policyholder's] determination of the Classification or Earnings of an Employee will be considered conclusive.]

["Coma"] or **["Comatose"]** mean a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.]

["Covered Rehabilitative Expense(s)"] means an expense that: (1) is charged for a Medically Necessary Rehabilitative Training Service of the Insured Person performed under the care, supervision or order of a Physician; (2) does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a Hospital room and board charge, does not exceed the most common charge for Hospital semi-private room and board in the Hospital where the expense is incurred); and (3) does not include charges that would not have been made if no insurance existed.]

["Dependent"] means an Employee's [Spouse] [who does not reside in the U.S.], [Domestic Partner] [who does not reside in the U.S.]] or [[Dependent Child [who does not reside in the U.S.]].]

DEFINITIONS (Continued)

["**Dependent Child**" and "**Dependent Children**" mean any unmarried child(ren) of the Employee, including natural, step, foster or adopted child(ren) who are:

1. under [19] years of age;
2. 19 years but under [23] years of age, if attending an accredited institution of higher learning on a full time basis) and primarily dependent on the Insured Employee for support and maintenance; or
3. 19 years of age or over and mentally or physically incapable of earning a living and primarily supported by the Insured Employee, provided the Insured Employee submits proof of the child's incapacity and dependency to the Insurance Company within 60 days before the date the Dependent Child fails to qualify under (1) or (2) above. If the Insured Employee fails to furnish the requested proof before the Dependent Child reaches the age limit, coverage for the Dependent Child will not be extended past the age limit. If coverage is extended, the Insurance Company may request that the Insured Employee submit satisfactory proof of the Dependent Child's continued incapacity and dependency to the Insurance Company on an annual basis. If the Insured Employee fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child will terminate at the end of that 31-day period.]

["**Domestic Partner**" means an [opposite] [or] [same] sex partner who has met all of the following requirements for at least [12] consecutive months: (a) resides with the Insured Person at the same permanent residence; (b) is not married to the Insured Person under either statutory or common law; (c) is not related by blood to the Insured Person to a degree of closeness that would prohibit a legal marriage in the jurisdiction in which they reside; (d) is at least the age of consent in the jurisdiction in which they reside; (e) neither the Insured Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner and (f) is financially interdependent with the Insured Person and has provided the [Participating Employer] [Policyholder] with at least two (2) of the following documents evidencing such financial interdependence:

- joint ownership of real property or a common leasehold interest in real property
- common ownership of an automobile
- joint bank account
- a will in which one partner designates the other as primary beneficiary
- a beneficiary designation form for a retirement plan, or life insurance policy signed and completed to the effect that one partner is the primary beneficiary of the other
- if the Insured Person and Domestic Partner reside in a jurisdiction which provides for registration of Domestic Partners, they have so registered and provided the [Participating Employer] [Policyholder] with evidence of such registration.

The Insurance Company also requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.]

"**Employee**" means a full-time Employee of the [Participating Employer] [Policyholder], including Employees of one or more subsidiary corporations, and the Employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the Employer and such affiliated corporations, proprietorships or partnerships is under common control. Employee shall exclude, in any case, part-time Employees, temporary Employees and Employees who work for the [Participating Employer] [Policyholder] [less than the number of hours per week indicated in the Schedule of Benefits].

"**Employer**" means the [Policyholder] [Participant Employer].

"**Evidence of Insurability**" means a statement or medical evidence of health that determines if a person qualifies for coverage under the Policy.

"**Expatriate**" means an Employee who is working outside his or her country of permanent residence.

"**Grace Period**" is the 31 days following a premium due date during which premium payment may be made.

DEFINITIONS (Continued)

["Guaranteed Issue Amount"] means the amount of insurance that will be issued to an Insured Person without Evidence of Insurability. The Guaranteed Issue Amount for an Insured Person's Life Insurance is shown in the Schedule of Benefits. For amounts in excess of the Guaranteed Issue Amount, Evidence of Insurability satisfactory to the Insurance Company must be provided at the Insured's expense.]

["Hospital"] means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.) on duty or call; and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, unless the Insured is legally required to pay for services in the absence of insurance.]

["Immediate Family"] includes an Insured Person's Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), aunt, uncle, niece, nephew, or grandchild.

["Injury"] means bodily injury resulting directly from an accident and independently of all other causes. The Injury must occur and disability must begin while the Employee is insured under this Policy.]

["Insurance Company"] means Delaware American Life Insurance Company. Any references to the terms "we", "us", and "our" will be deemed references to the Insurance Company.

["Insured"] means an Employee insured under this Policy.

["Insured Dependent"] means an Insured Dependent Child or an Insured Spouse, for whom premium is paid while covered under the Policy.]

["Insured Dependent Child"] or **["Insured Dependent Children"]** mean the Employee's Dependent Child(ren), for whom premium is paid while covered under the Policy.]

["Insured Employee"] means an Employee for whom premium is paid while covered under the Policy.

["Insured Person"] means an Insured Employee [or an Insured Dependent].

["Insured Spouse"] means the Employee's Spouse, for whom premium is paid while covered under the Policy.]

["Key Local National"] means an Employee of the [Policyholder] [Participating Employer] working and residing within his or her country of permanent residence and who the [Policyholder] [Participating Employer] has designated as essential to the management of that country's operation.

["Medically Necessary Rehabilitative Training Service"] means any medical service, medical supply, medical treatment or Hospital confinement (or part of a Hospital confinement) that: (1) is essential for physical rehabilitative training due to the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.]

["Participating Employer"] means an Employer who is part of a trust established to insure Employees of the Employer or any parent, subsidiary or its affiliated companies under a common control.]

DEFINITIONS (Continued)

["Physician"] means an individual who is operating within the scope of his or her license and is licensed to prescribe and administer drugs or to perform surgery. **Note:** For the purpose of the Policy, a duly licensed dentist, chiropractor, podiatrist or other practitioner acting within the scope of their licenses will be considered on the same basis as a Physician to the extent that the services are covered under the Policy.

It will not include an Employee or his or her Spouse, daughter, son, father, mother, sister or brother.]

["Policyholder"] may be an Employer, including any parent, subsidiary or affiliated company or the trust which the Employer created or participates in.

["Pre-existing Condition"] means a disease or physical condition for which the Insured Person received medical advice, treatment, consultation or care by a Physician, including diagnostic measures or for which the Insured Person took prescribed drugs or medicines during the [six] months prior to the Insured Person's effective date of coverage under the Policy.]

["Serious Injury"] or **["Sickness"]** means Injury or Sickness certified as being dangerous to life by a legally qualified medical practitioner

["Sickness"] means any physical Sickness, Mental Illness, Substance Abuse or functional nervous disorder diagnosed by a Physician. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. [The term "Sickness" also includes pregnancy.]

["Spouse"] means the Insured Employee's lawful spouse (not including a spouse who is legally separated from the Insured). [The term Spouse will include a Domestic Partner.]]

["Supplemental Restraint System"] means an air bag which inflates for added protection to the head and chest areas.]

["Third Country National"] means an Employee who works outside his or her country of permanent residence and outside the [Policyholder] [Participating Employer]'s country of domicile.

["Total and Permanent Disability"] or **["Totally and Permanently Disabled"]** mean that, as a result of Injury or Sickness, the Insured Employee is permanently unable to engage in any occupation for which he or she is reasonably qualified by education, training or experience.]

["Total Disability"] or **["Totally Disabled"]** mean that, as a result of Injury or Sickness, the Insured Employee is unable to engage in any occupation for which he or she is reasonably qualified by education, training or experience.]

[A Dependent will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is unable to engage in the normal activities of a person of the same age and sex.]]

["Waiting Period"], shown in the Schedule of Benefits, means the continuous length of time an Employee must serve in an eligible class to reach his eligibility date.

ELIGIBILITY FOR INSURANCE

EMPLOYEES

Each Employee in a class of Eligible Employees will become eligible for insurance on the date he or she completes the Waiting Period, if any. Any Waiting Period will be waived for an Employee previously insured under the Policy, whose insurance terminated for a reason other than cancellation of his or her payroll deduction order, if the Employee becomes employed in one of the classes of Eligible Employees within one year after his or her insurance terminates. The classes of Eligible Employees and the Waiting Period are shown in the Schedule of Benefits.

[DEPENDENTS

Each Eligible Employee will be eligible with respect to his or her Dependents on the latest of:

1. the effective date of the Policy; or
2. the date upon which he or she acquires a Dependent; or
3. the effective date of the Employee's insurance under the Policy.]

EFFECTIVE DATE OF INSURANCE

EMPLOYEES

[Non-Contributory [– All Coverage's]

If the [Participating Employer's] [Policyholder's] plan under the Policy or the coverage afforded there under is issued on a non-contributory basis, an Eligible Employee's coverage will become effective on the later of:

1. the effective date of the Policy; or
2. the date such Employee becomes eligible for coverage under the Policy.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

[Contributory [– All Coverage's]

If the [Participating Employer's] [Policyholder's] plan under the Policy or any coverage afforded there under is issued on a contributory basis, each Employee may elect for such insurance by signing an enrollment form approved by the [Participating Employer] [Policyholder] and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the [Participating Employer] [Policyholder] on or before that date; or
2. the date on which the enrollment form is received by the [Participating Employer] [Policyholder], if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the [Participating Employer] [Policyholder] more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

EFFECTIVE DATE OF INSURANCE
(continued)

[Open Enrollment. The Open Enrollment Period, shown in the Schedule of Benefits, is a period of time agreed upon by the Policyholder and the Insurance Company, during which: (a) members of an Eligible Class may apply for insurance; and (b) Insureds may elect to make changes in their amount of insurance or apply for additional insurance. Any changes made during the Open Enrollment Period will take effect on the date shown in the Schedule of Benefits. Any changes in the amount of insurance during the Open Enrollment will be limited to [one incremental increase]. All other increases will be subject to Evidence of Insurability]

[Annual Enrollment. The Annual Enrollment Period, shown in the Schedule of Benefits, is a period of time during which any Eligible Insured's may apply for insurance or elect to make changes in their amount of insurance. Any changes in the amount of insurance during an Annual Enrollment will be limited to [one incremental increase]. Any increase either over the Guarantee Issue or more than the limited change amount will be subject Evidence of Insurability.]

[DEPENDENTS

[Non-Contributory [– All Coverage's]

An Insured Dependent's coverage under the Policy will become effective on the later of:

1. the date the Insured Employee becomes eligible for Dependent insurance; or
2. the Insured Employee's effective date of coverage under the Policy.]

[Contributory [– All Coverage's]

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] on or before the date he or she become eligible for coverage under the Policy; or
2. the date the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder], if it is received within 30 days of the date the or she becomes eligible for coverage under the Policy; or
3. the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is confined to a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.]]

EFFECTIVE DATE OF INSURANCE
(continued)

[INCREASES AND DECREASES IN AMOUNTS OF INSURANCE

Any increase in or addition to the benefits will take effect on the date of the change.

However, any such change applies only to [loss of life or Accidental Injury that occurs] on or after the effective date of the change.

If an Insured Employee is not in Active Service on the date the increase or addition is to take effect, it will take effect when he or she returns to Active Service. [If an Insured Dependent is confined in a Hospital, or other medical facility on the date the increase or addition is to take effect, it will take effect when the confinement ends].

Any decrease in or deletion of benefits will take effect on the date of the change.]

[NO LOSS/NO GAIN

If you are absent from work due to a physical or mental condition on the date your insurance would otherwise have become effective, the effective date of your insurance will be deferred until the date you return to work as an Active Full-time Employee.

If you were insured under the Prior Plan on the day before the Policy Effective Date and you would be eligible for coverage on the Policy Effective Date; except that you are not able to meet the requirements of Actively at Work; then the coverage amount shown in the Schedule of Benefits will not apply to you.

Instead, you will be considered to be insured and our coverage amount will be the lesser of:

1. the amount of Life Insurance under the Prior Plan; or
2. the amount of Life Insurance shown in the Schedule of Benefits,

reduced by:

1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. [any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.]

You will remain insured under this provision until the first to occur of:

1. the date you return to work as an Active Full-time Employee;
2. the date your insurance terminates for a reason stated under the termination provision;
3. the last day of a period of [12] consecutive months which begins on the Policy Effective Date; or
4. the last day you would have been covered under the Prior Plan, had the Prior Plan not terminated.]

TERMINATION OF INSURANCE

EMPLOYEES

An Insured Employee's coverage under the Policy will automatically terminate on the earliest of:

1. the date the Employee ceases to be in a class of Eligible Employees or ceases to qualify as an Employee;
2. the date the Employee's Employer ceases to be the [Participating Employer] [Policyholder] of the Policy;
3. the date the Policy is discontinued;
4. the last day for which any required contribution has been made;
5. [[90 days] after the date the Employee returns to the U.S to establish residency;]
6. the date the Employee ceases to be in Active Service, except as provided below:

Temporary Layoff or Leave of Absence. If an Employee's Active Service terminates because of temporary layoff or leave of absence, the insurance will be continued until the [Participating Employer] [Policyholder] ceases to pay premiums for the Employee or otherwise cancels the insurance. But in no event will the insurance be continued for more than [60 days] following termination of Active Service.

Any continuation of insurance must be in accordance with a plan which precludes individual selection.

[DEPENDENTS

An Insured Dependent's coverage under the Policy will automatically terminate upon the earliest of the following:

1. the date the Insured Employee's coverage under the Policy ends; or
2. the last day for which any required contribution has been made;
- [3. [90 days] after the date the Dependent returns to the U.S to establish residency;]
4. the date the person ceases to qualify as a Dependent.]

[LIFE INSURANCE

Amount of Insurance. The amount of insurance on each Insured Employee will be equal to the Maximum Amount(s) for which he or she is eligible on the day he or she becomes insured as shown in the Schedule of Benefits. However, if such amount of insurance is greater than the Guaranteed Issue Amount; his or her amount of insurance will be the Maximum Amount for which he or she is eligible only if he or she submits medical Evidence of Insurability satisfactory to the Insurance Company. If an Employee does not satisfy this insurability requirement, his or her amount insurance will be the Guaranteed Issue Amount.

DEATH BENEFIT

Upon receipt by the Insurance Company of proof of the death of an Insured Employee, the Insurance Company will pay to the beneficiary the Maximum Amount(s) of insurance in force on the life of the Insured Employee determined in accordance with the terms of the Policy.

[EXTENDED DEATH BENEFIT

If an Insured Employee's active service is terminated prior to his or her [65th] birthday because of Total Disability, and if the [Participating Employer] [Policyholder] continues to pay premiums for the Insured Employee, the insurance will be extended during the period he or she remains Totally Disabled, but for no more than one year from the date on which the disability began. In the event of the Insured Employee's death during the period in which the insurance is being extended, no death benefit will be paid unless proof of the Total Disability is submitted to the Insurance Company within one year after his or her death.

The amount of insurance payable at death will be the same amount for which the Insured Employee would have been eligible if he or she were not Totally Disabled, subject to any benefit reduction indicated in the Schedule of Benefits.

At any time during the period in which the insurance is extended, the Insurance Company will have the right to require proof of the continuing Total Disability and to have a Physician of its choice examine the Insured Employee.

There will be no extension of insurance under the provisions of this section if an individual policy of Life insurance is issued to the Insured Employee under the Conversion Privilege, unless the individual policy is surrendered to the Insurance Company without claim except for the return of any premium paid.

The insurance which is being extended on any Insured Employee under the provisions of this section will automatically terminate: (a) when premium payments stop; (b) if the Insured Employee ceases to be Totally Disabled, except that if he or she returns to Active Service in an Eligible Class, the insurance on the Insured Employee will be continued subject to payment of premiums by the [Participating Employer] [Policyholder] for him or her; (c) if the Insured Employee refuses to submit to any physical examination required by the Insurance Company; (d) if the Insured Employee fails to provide proof of Total Disability in accordance with the terms of this section; or (e) the discontinuance of the Policy. Upon termination of his or her insurance, the Insured Employee will be entitled to the benefits described in the section entitled "Conversion Privilege".]

[WAIVER OF PREMIUM

If an Insured Employee becomes and remains Totally Disabled, as defined, before reaching age [60], life insurance under the Policy will continue for one year from the date the Insured Employee became Totally Disabled, provided that premiums are paid when due. The Insured Employee's life insurance benefit will be the same amount for which he or she would have been eligible if he or she were not Totally Disabled, subject to any benefit reduction indicated in the Schedule of Benefits. In the event of the Insured Employee's death during the period in which the insurance is being continued, no death benefit will be paid unless proof of the Total Disability is submitted to the Insurance Company. Such insurance will continue beyond the one year period if the Insured Employee:

1. furnishes proof satisfactory to the Insurance Company, at least nine months from the date his or her Total Disability began, that he or she has been Totally Disabled continuously from the date the Total Disability began; and
2. such proof is furnished no later than one year after the date the Total Disability began.

At any time during the period in which the insurance is extended, the Insurance Company will have the right to require proof of the continuing Total Disability and to have a Physician of its choice examine the Insured Employee.

LIFE INSURANCE (Continued)

Waiver of Premium (continued)

There will be no extension of insurance under the provisions of this section if an individual policy of life insurance is issued to the Insured Employee under the Conversion Privilege, unless the individual policy is surrendered to the Insurance Company without claim except for the return of any premium paid.

The Company will waive the required premium payments until the Insured is no longer Totally Disabled, provided the Insured: (a) furnishes proof that the Total Disability has continued uninterrupted; and (b) submits to a physical exam when required, as provided below.

Benefits will end on the earliest of the following dates:

1. the date the Insured ceases to be Totally Disabled;
2. the date the Insured fails to submit to a physical exam as required;
3. the date the Insured's Life Insurance would otherwise terminate as indicated in this Policy;
4. the date proof of Total Disability is not provided when due; or
5. [the date the Insured reached age [70].]

If the Insured ceases to be Totally Disabled, premiums must be paid when due if insurance coverage is to be continued.

Upon termination of his or her insurance, the Insured Employee will be entitled to the benefits described in the section entitled "Conversion Privilege".]

[TOTAL AND PERMANENT DISABILITY BENEFIT

If the Insured Employee becomes Totally and Permanently Disabled, as defined, before reaching age [60], and remains Totally and Permanently Disabled, the life insurance benefit will be payable in monthly installments. The first installment will be payable [six months] after the date Total and Permanent Disability began, provided the Insured Employee has furnished to the Insurance Company satisfactory proof of the Total and Permanent Disability. Proof must be given to the Insurance Company no later than one year after the commencement of such Total and Permanent Disability.

Installments will be paid in equal amounts for [60] consecutive months until the total amount of the benefit has been paid and insurance under the Policy terminates. If the Insured Employee dies before installments due are paid in full, all unpaid installments will be paid to the Insured Employee's beneficiary.

Benefits will end on the earliest of the following dates:

1. the date the Insured Employee ceases to be Totally and Permanently Disabled;
2. the date the Insured Employee fails to submit to a physical exam as required;
3. the date the Insured Employee's life insurance would otherwise terminate as indicated in the Policy; or
4. the date proof of Total and Permanent Disability is not provided when due; or
5. the date the last installment is paid on behalf of the Insured Employee.

If the Insured ceases to be Totally and Permanently Disabled, premiums must be paid when due if insurance coverage is to be continued.]

[CONVERSION PRIVILEGE

The Insured Employee may convert his or her life insurance under the Policy to an individual policy if such insurance or any portion of it, ends, provided the Insured Employee is Entitled to Convert and, within 31 days after such insurance ends the Insured Employee:

1. applies in writing to the Insurance Company at [One Alico Plaza, P.O. Box 667, Attn.: GMD, Wilmington, DE 19899]; and
2. pays the first premium.

LIFE INSURANCE
(Continued)

CONVERSION PRIVILEGE (continued)

Evidence of Insurability. No Evidence of Insurability will be required if the Insured Employee converts to an individual policy under the Conversion Privilege.

Entitled to Convert. The Insured Employee is Entitled to Convert his or her Life Insurance only if:

1. the Insured Employee ceases to be a member of an Eligible Class as shown the Schedule of Benefits;
2. the Policy terminates, provided the Insured Employee has been covered under the Policy for at least [five] consecutive years immediately preceding such termination;
3. the Policy is amended to terminate the Eligible Class to which the Insured Employee belongs, provided he or she has been covered under the Policy for at least [five] consecutive years immediately preceding such termination.

In no event will the Insured Employee be Entitled to Convert if his or her coverage under the Policy ceases due to non-payment of the required premium.

Amount of Converted Life Insurance. If the Insured Employee's coverage terminates because he or she is no longer a member of an Eligible Class, the amount of Life Insurance that he or she will be eligible to convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Insured Employee's Life Insurance ends because the Policy is amended to terminate the Eligible Class to which he or she belongs, or if the Policy terminates, the amount of Life Insurance under the converted life policy will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time insurance ends, less any amount for which the Insured Employee becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) \$[2,000].

Type of Policy. The individual policy will be the Insurance Company's current offering and will be on a form customarily issued by the Insurance Company. However, such policy may not be term insurance. No disability or other supplemental benefits will be covered under the Policy. The individual policy will go into effect at the end of the period during which the Insured Employee is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the Policy can be contested, such time periods will be deemed to have begun at the time the Insured Employee was first covered under the Policy.

The premium will be based on the Insurance Company's rates for the individual policy form, the benefit amount, age and the class of risk to which the Insured Employee belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

Death During the Conversion Period. If the Insured Employee dies within the 31-day conversion period, the Insurance Company will pay a death benefit equal to the maximum amount the Insured Employee could have otherwise converted.

Notice of Conversion Right. Notice of the Insured Employee's right to convert to an individual policy will be presented to the Insured Employee or delivered to the Insured Employee's last known address within 15 days from the date his or her coverage ends. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.]

[ACCELERATED LIFE INSURANCE BENEFIT

If elected by the Insured Employee and subject to approval by the Insurance Company, a portion of the Insured Employee's Life Insurance benefit may be paid before his or her death. To qualify for this benefit, the Insured Employee must have been diagnosed as being terminally ill while insured under the Policy. The Insured Employee must apply for Accelerated Life Insurance benefits in writing on a form acceptable to the Insurance Company.

**LIFE INSURANCE
(Continued)**

ACCELERATED LIFE INSURANCE BENEFIT (continued)

The maximum benefit the Insured Employee may receive under this provision is the lesser of:

1. [50%] of the Insured Employee's Life Insurance benefit shown in the Schedule of Benefits, including any Supplemental Life Insurance benefit less the amount of any benefit already paid under this provision; or
2. \$[100,000].

However if the Insured Employee's Life Insurance is scheduled to reduce within [12 months] of the date application for this benefit is received by the Insurance Company, the Accelerated Life Insurance Benefit will be limited to the amount that would be available for accelerated payment after such reduction takes place.

The minimum Accelerated Life Insurance benefit the Insured Employee may receive will be \$[15,000]. Such benefit will be paid in a lump sum to the Insured Employee, unless an alternate payment arrangement is requested by the Insured Employee in writing and is approved by the Insurance Company. However, the minimum payment under such installment payment arrangement will be \$[500] per payment. The Insurance Company may also charge a fee of not more than \$[25] for each payment processed under such a payment arrangement.

Interest. The Insurance Company will charge interest on the amount of the Accelerated Life Insurance benefit. The interest will accrue daily at a rate not exceeding the greater of the current yield on 90-day treasury bills or the current maximum statutory adjustable policy loan interest rate. On the Policy Anniversary Date, interest accrued will be considered a benefit paid toward the Accelerated Life Insurance benefit. No additional Accelerated Life Insurance benefits will be payable under the Policy if the benefits paid plus the accrued interest equals the Insured Employee's Life Insurance Benefit Amount(s) shown in the Schedule of Benefits.

Proof of Terminal Illness. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Insurance Company that the Insured Employee's life expectancy is [12 months] or less from the date of application for this benefit. Proof of terminal illness must include certification from a Physician. The Insurance Company reserves the right to obtain a second or third medical opinion at its own expense.

The receipt of this Accelerated Life Insurance benefit may be taxable. The Insured Employee should seek assistance from a personal tax advisor with respect to receipt of this benefit. No representations as to any issue of taxation of this benefit are made by the Insurance Company.

Effect on Life Insurance Benefits at Insured Employee's Death. The Insured Employee's Maximum Amount(s) shown in the Schedule of Benefits will be reduced by any amount paid and interest charged under this provision.

Termination of Accelerated Life Insurance Benefits. This benefit will terminate on the date the Insured Employee's insurance under the Policy terminates. [However, this benefit will continue to be available while the Insured Employee is covered under the Extension of Life Insurance provision of the Policy.]

Limitations. The Insurance Company will not provide benefits under this provision if:

1. the Insured Employee would be required by law to use the benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
2. the Insured Employee is required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement;
3. the Insured Employee's Life Insurance under the Policy has terminated;
4. each irrevocable beneficiary, if any, has disapproved payment of this benefit; or
5. the Insured Employee's Life Insurance benefits under the Policy have been assigned; or
6. the Insured Employee has attained 65 years of age as of the date application for this benefit has been received by the Insurance Company.]

LIFE INSURANCE (Continued)

[DEPENDENT LIFE INSURANCE

Upon receipt of proof of the death of an Insured Dependent, the Insurance Company will pay the Maximum Amount of Dependent Life Insurance in force on the life of such Insured Dependent at the time of the Insured Dependent's death, in accordance with the terms of the Policy. In no event will the total amount of insurance for an Insured Dependent exceed the Maximum Amount shown in the Schedule of Benefits.]

[PORTABILITY

If an Insured Employee ceases to be a member of an Eligible Class for any reason other than retirement, the Insured Employee may elect to continue his or her [Supplemental] Life Insurance under the Policy provided he or she has not attained age 70. [The Insured Employee may also elect to continue Dependent Life Insurance on his or her Insured Spouse provided the Insured Spouse has not attained age 70.] The Insured Employee must: (a) make such election within 31 days of termination of eligibility; and (b) agree to pay the entire premium for such continued coverage.

Continued coverage will be subject to all of the provisions and limitations of the Policy, including reductions for age or termination at an age. [However, in no event shall coverage continue beyond age [75].] Renewal rates for coverage continued under this provision will be based on the continuing person's age, sex and smoking status at the time of renewal. Coverage continued under this provision will [survive termination of the Policy but will end at the expiration of the last period through which premiums have been paid] [end when the Policy terminates but will continue through the last period for which premiums have been paid]. Premiums for continued coverage will be billed directly to the terminated individual on a quarterly, semi-annual or annual basis, as elected by the Insured Employee.

The Insured Employee may elect to convert his or her continued coverage at any time while such coverage is in force as set forth in the Conversion Privilege provision of the Policy. If continued coverage terminates for any reason other than non-payment of premium, the Insured Employee may be eligible to convert his or her coverage as set forth in the Conversion Privilege provision of the Policy.]

EXCLUSIONS

Benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. [suicide or any attempt thereat by the Insured Person [or a dependent's] within two years of the effective date of such Insured Person's coverage under the Policy;]
2. [an Insured's [or a dependent's] death caused by a Pre-existing Condition if death occurs within [24] months after his or her effective date of coverage under the Policy;]
3. [an Insured's [or a dependent's] death caused by or attributed to the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) if death occurs within [24] months after his or her effective date of coverage under the Policy;]
4. [the commission of or attempt to commit a felony;]
5. [the participation in a riot or insurrection;] or
6. [the [active participation in] declared or undeclared war, or [active participation in] any act of declared or undeclared war.]]
7. [an insured's death caused as a result of radiological, nuclear, chemical, or biological weapons or events]

[ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Amount of Principal Sum. The amount of Principal Sum on each Insured Employee will be equal to the Principal Sum for which he or she is eligible on the day he or she becomes insured as shown in the Schedule of Benefits.

DEATH AND DISMEMBERMENT BENEFIT

When an Insured Employee suffers any of the following losses within [120-365] days of and solely as the result of Injury that occurs while insured, the Insurance Company will pay in one sum the indicated percentage of Principal Sum for:

Schedule of Losses

Table with 2 columns: Loss of: and Percentage of Principal Sum. Rows include Life, Both Hands or Both Feet, Sight of Both Eyes, One Hand and One Foot, One Hand and Sight of One Eye, One Foot and Sight of One Eye, [Speech and Hearing in Both Ears], One Hand or One Foot, Sight of One Eye, [Speech or Hearing in Both Ears], [Hearing in One Ear], and [Thumb and Index Finger of Same Hand].

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. [“Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss of speech” means total and irrecoverable loss of the entire ability to speak.][“Loss” of thumb and index finger means the complete severance through or above the metacarpophalangeal joint of both digits.]

SEAT BELT AND AIR BAG BENEFIT

Seat Belt Benefit (Percentage of Principal Sum Amount). The company will pay a benefit when the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the accident causing death occurs while the insured is operating, or riding as a passenger in, an Automobile and wearing properly fastened, original, factory-installed seat belt. The amount payable is the lesser of: (1) \$25,000.00 or (2) 10% of the Insured Person’s Principal Sum.

Air Bag Benefit (Percentage of Principal Sum Amount). The company will pay an additional benefit if a Seat Belt Benefit is payable and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable is the lesser of: (1) \$25,000.00 or (2) 10% of the Insured Person’s Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System that inflates on impact. The additional amount payable is the lesser of: (1) \$25,000.00 or (2) 10% of the Insured Person’s Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

**ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
(Continued)**

COMA BENEFIT

If Injury renders an Insured Person Comatose within 90 days of the date of the accident that caused the Injury, and if the Coma continues for a period of 30 consecutive days, the Insurance Company will pay a monthly benefit of 1% of the Principal Sum. No benefit is provided for the first 30 days of Coma. The benefit is payable monthly as long as the Insured Person remains Comatose due to that Injury, but ceases on the earliest of: (1) the date the Insured Person ceases to be Comatose due to that Injury; (2) the date the Insured Person dies; or (3) the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals 100% of the Principal Sum. The Insurance Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Insurance Company is liable when the Insured Person is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

The Insurance Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at the expense of the Insurance Company.

REHABILITATION BENEFIT

If an Insured Person suffers an accidental dismemberment or paralysis for which an Accidental Dismemberment and Paralysis benefit is payable under the Policy, the Insurance Company will reimburse the Insured Person for Covered Rehabilitative Expenses that are due to the Injury causing the dismemberment or paralysis. The Covered Rehabilitative Expenses must be incurred within two years after the date of the accident causing that Injury, up to a maximum of [\$10,000] for all Injuries caused by the same accident.

Exclusions. In addition to the Exclusions in the General Exclusions section of the Policy, Covered Rehabilitative Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

WAIVER OF PREMIUM BENEFIT FOR ACCIDENTAL DEATH & DISMEMBERMENT

This provision applies only with respect to an insured receiving disability benefits under a disability plan provided through the **[Policyholder]** **[Participating Employer]** where the Insured's disability begins on or after the date coverage under the Policy begins for that Insured. It is subject to all of the Policy provisions, limitations and exclusions of the Policy except as they are specifically modified by this provision.

Waiver of Premium Benefit. Subject to the Policy remaining in force, all premiums due under the Policy on behalf of an Insured who is receiving disability benefits under a disability plan provided through the **[Policyholder]** **[Participating Employer]** will be waived. Premiums will be waived from the first premium due date on or after the date the disability benefits begin. Premium payments must be resumed on the premium due date next following: (1) the date the Insured returns to work; or (2) the date when such disability benefits are stopped, whichever occurs first. If premium payments are not resumed on that date, the Insured's coverage under the Policy ends on that date.

The Principal Sum amount that applies during the time premiums are waived is the lesser of: (1) \$2,000,000.00; or (2) the principal sum in force on the insured on the date the disability began.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
(Continued)

EXCLUSIONS

Benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

- [1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury;]
- [2. Sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning;]
- [3. the Insured Employee's commission of or attempt to commit a felony;]
- [4. the Insured Employee's participation in a riot or insurrection;]
- [5. [active participation in] declared or undeclared war, or [active participation in] any act of declared or undeclared war.]
- [6. full-time active duty in the armed forces of any country or international authority, except the National Guard or organized reserve corps duty (unearned premium will be returned if the Insured Employee enters military service).]
- [7. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Employee is:
 - a. riding as a passenger in any aircraft not licensed for the transportation of passengers for hire.
 - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft.]
- [8. the Insured Employee's being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.]
- [9. a work related Injury.]
- [10. radiological, nuclear, chemical, or biological weapons or events]]

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within [20] days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at [One Alico Plaza, P.O. Box 667, Attn.: GMD, Wilmington, DE 19899], with information sufficient to identify the Insured Person, is deemed notice to the Company.

Claim Forms. The Insurance Company, when it receives the notice of claim directly from the [Participating Employer] [Policyholder], will furnish to the [Participating Employer] [Policyholder] for delivery to the Employee or the Beneficiary, the claim forms which it usually furnishes for filing proofs of loss. If the Employee or Beneficiary does not receive these claim forms within [15] days after receipt by the Insurance Company of the notice of claim, the Employee may submit any other written proof which fully describes the nature and extent of your claim.

Proofs of Loss. Written proof of loss must be furnished to the Insurance Company at its Home Office within [90] days after the date of the loss for which claim is made. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Insurance Company may reasonably require. Failure to furnish written proof of loss within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to furnish written proof of loss within that time and that written proof of loss was furnished as soon as was reasonably possible.

Time of Payment of Claims. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the Insurance Company's receipt of written proof of the loss. Subject to the Insurance Company's receipt of written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Insurance Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Payment of Claims. Upon receipt of death certificate or some other proof of death suitable to the Insurance Company, payment for loss of life of an Insured Employee will be made to the Insured Employee's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Employee. If an Insured Employee dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Insurance Company may make an initial payment, up to an amount not exceeding [\$5,000], to any relative by blood or connection by marriage of the payee who is deemed by the Insurance Company to be equitably entitled thereto. Such payment does not discharge the Insurance Company's liability for any remaining benefits payable under the Policy.

Any payment the Insurance Company makes in good faith fully discharges the Insurance Company's liability to the extent of the payment made.

Facility of Payment. If an individual appears to the Company to be equitably entitled to compensation because he or she has incurred expenses on behalf of an Insured Person or for burial or funeral expenses, the Company may deduct from the amount payable under the Policy to be paid to such individual the expenses incurred, but not more than [\$500]. Such payment will not exceed the amount due under the Policy.

GENERAL PROVISIONS

Legal Actions. No action at law or in equity will be brought to recover on the Policy prior to the expiration of [60] days after written proof of loss has been filed in accordance with the requirements of the Policy, nor will any action be brought at all unless brought within [three] years from the expiration of the time within which proof of loss is required by the Policy.

Time Limitations. If any time limitation provided in the Policy for giving notice of claims, for furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the jurisdiction in which the Employee resides at the time the Policy is issued, then the time limitation of the prevailing jurisdiction.

Physical Examination and Autopsy. The Insurance Company, at its own expense, will have the right and opportunity to examine any individual for whom claim is pending under the Policy when and as often as it may reasonably require and to make an autopsy in case of death where it is not forbidden by law.

Beneficiary Designation and Change. The Insured Employee's designated beneficiary is the person(s) so named by the Insured Employee for the Policy as shown on the [Policyholder's] [Participating Employer's] records kept on the Policy. [The Insured Dependent's beneficiary is the Insured Employee.]

A legally competent Insured Employee over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Insurance Company, Administrator, or broker or, if agreed upon in advance by the Insurance Company, the [Policyholder] [Participating Employer] with a written request for change. When the request is received by the Insurance Company, Administrator, or broker or, if agreed upon in advance by the Insurance Company, the [Policyholder] [Participating Employer], whether the Insured Employee Person is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Insurance Company on account of any payment which is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living after the Insured Employee's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Insured Employee's (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured Employee Person's estate.

[If no beneficiary for an Insured Dependent's coverage is living on the date of the Insured Dependent's death, the beneficiary is the Insured Employee's estate.]

Honoring Beneficiary Information from a Prior Plan during transition period. The Insured Employee's beneficiary should be named on a form acceptable to the Insurance Company within [30] days of the effective date of coverage under this plan. If a claim is presented within [30] days of the effective date of coverage under this Policy and the Employee has not submitted a beneficiary designation acceptable to the Insurance Company then the Company may make all payments to the last person named by the Insured Employee as a beneficiary under a policy that ended before becoming insured under the Policy.

The Insurance Company may use information from the prior carrier's records to determine any payment made such as:

1. information about the last beneficiary named by the Insured Employee under the Policy, or any other group policy; or
2. information that the Insured Employee named no beneficiary under the Policy, or any other group policy.

If information shows that no beneficiary was named, the Insurance Company may make all payment to anyone it selects under the provisions for Payment of Benefits.

Assignment. The Policy is non-assignable by the [Participating Employer] [Policyholder]. An Insured Employee may assign all of his or her rights, privileges and benefits under the Certificate without the consent of his or her beneficiary. However, the Insurance Company is not bound by an assignment until received by the insurance company. The Insurance Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to any laws and the terms of the Policy.

GENERAL PROVISIONS
(Continued)

Reimbursement and Subrogation. When an Insured Person's Injury appears to be someone else's fault, benefits otherwise payable under the Policy for covered expenses incurred as a result of that Injury will not be paid unless the Insured Person or his legal representative agrees:

1. to repay the Insurance Company for such benefits to the extent they are for losses for which compensation is paid to the Insured Person by or on behalf of the person at fault;
2. to allow the Insurance Company a lien on such compensation and to hold such compensation in trust for the Insurance Company; and
3. to execute and give to the Insurance Company any instruments needed to secure the rights under (a) and (b).

Further, when the Insurance Company has paid benefits to or on behalf of the injured Insured Person, the Insurance Company will be subrogated to all rights of recovery that the Insured Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Insurance Company has paid. The Insured Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Insurance Company.

Conformity with State Statutes. Any provision of the Policy which, as of its Effective Date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

[ERISA INFORMATION]

This Employee Benefit Plan (the "Plan"), sponsored by [ABC Industries, Inc.] is intended to comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The following information, together with the information contained in this booklet complies with the Plan Administrator's ERISA disclosure obligations. This information is furnished by the Plan Administrator and is not a part of the Policy. The Policy may be obtained from the Plan Administrator or the Insurer by written request at the addresses listed below.

PLAN NAME: [Employee Benefit Plan]

PLAN NUMBER: [000]

PLAN SPONSOR/PLAN ADMINISTRATOR: [ABC Industries, Inc.
101 N. Main Street
Anytown, DE 19801]

EMPLOYER IDENTIFICATION NUMBER (EIN):[XX-XXXXXX]

PLAN TYPE: This booklet provides information about the Group [Life], [Accidental Death and Dismemberment], [Supplemental Life], [Supplemental Accidental Death and Dismemberment], [Long Term Disability], [Medical], [Dental], and [Vision] Insurance for Employees covered under the Plan and [Dependent Life], [Dependent Accidental Death and Dismemberment], [Medical], [Dental] and [Vision] benefits for Employee's Dependents.

TYPE OF ADMINISTRATION: Insurer administration -
Delaware American Life Insurance Company
600 King Street
Wilmington, DE 19801

PLAN ADMINISTRATION:

The Plan is administered by the Plan Administrator which is the Named Fiduciary for the Plan. The Plan Administrator has discretionary authority to determine the status and rights of participants, beneficiaries and other persons, to construe and interpret Plan terms, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be sufficient to warrant deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire and Rubber Co. v. Bruch.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

ERISA INFORMATION
(Continued)

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Group [Life], [Accidental Death and Dismemberment], [Supplemental Life], [Supplemental Accidental Death and Dismemberment], [Dependent Life], [Dependent Accidental Death and Dismemberment], [Long Term Disability], [Medical], [Dental], and [Vision] Insurance benefits described in this benefit booklet are provided pursuant to an insurance contract issued to [ABC Industries, Inc.] by The Delaware American Life Insurance Company. Delaware American life Insurance Company is the Claims Administrator for these Group [Life], [Accidental Death and Dismemberment], [Supplemental Life], [Supplemental Accidental Death and Dismemberment], [Dependent Life], [Dependent Accidental Death and Dismemberment], [Long Term Disability], [Medical], [Dental], and [Vision] Insurance benefits. The Plan Administrator has delegated to Delaware American Life Insurance Company its entire discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the contract.

WAIVER:

Failure by the Plan or Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

GOVERNING LAW:

The Plan shall be interpreted under federal law, including ERISA, and by the laws of the State of Delaware, to the extent not preempted.

THE AGENT FOR SERVICE OF LEGAL PROCESS:

[ABC Industries, Inc.
101 N. Main Street
Anytown, DE 19801]

SOURCE OF CONTRIBUTIONS:

[The Employer and Employees share in the cost of this Insurance.] [The Employer pays the cost of this Insurance.]

PLAN YEAR:

The fiscal records of the Plan are kept on a [Plan] [Calendar] year basis, [July 1 through June 30].

ERISA INFORMATION
(Continued)

PLAN MODIFICATION, AMENDMENT AND TERMINATION:

The Insurance Company reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all provisions of the Plan, including termination of the Plan. Amendments to this Plan, or termination of this Plan, are to be made by a written resolution adopted in accordance with the established procedures of the Board of Directors. Amendments may be adopted with retroactive effect to the extent permitted by ERISA and the Code. Any change will affect all covered persons, including Dependents, retirees and disabled individuals.

CLAIM DENIALS AND APPEAL OF DENIED CLAIMS:

If a claim is denied in whole or in part, the covered person will receive a written notification within 90 days from the date the claim was submitted. If additional information is needed for consideration of the claim, the Insurer/Claims Administrator will request it from either the provider of the service or the covered person. If special circumstances warrant an extension of time, a written notice will contain an explanation of the special circumstances necessitating the extension. In no event shall the extension exceed a period of 90 days from the end of the initial period (i.e., 180 days from the date the claim was submitted). For all claims, an explanation of benefits form will be provided by the Insurer/Claims Administrator showing the calculation of the total amount payable, the charges not payable, and the reason for the denial of any charges not covered. If an explanation of why the benefits were denied is not received by the end of the 90 day period (or 180 days if an extension is requested), the claim should be deemed denied.

Any covered person may request a review of the denial of any benefit claim by submitting a written request for review to the Insurer/Claims Administrator. This must be done within 60 days after the denial is received by the covered person (or 60 days from the expiration of the period after which the claim is deemed denied).

Any covered person and/or his authorized representative may examine pertinent documents which the Plan Administrator has and submit opinions and comments. The decision of the Insurer/Claims Administrator regarding a request for a review of a denied claim will be in writing and will be made within 60 days of receiving a request for review of a denied claim, unless special circumstances require an extension of time. If special circumstances warrant an extension of time, a written notice of the extension will be sent prior to the expiration of the original 60 day period. Such notice shall contain an explanation of the special circumstances necessitating the extension. In no event shall the extension exceed a period of 60 days from the end of the initial period (i.e., 120 days from the date of the request for review).

The decision of the Insurer/Claims Administrator will be delivered to the covered person in writing and will set forth the specific reasons for the decision and specific references to pertinent provisions of the Plan on which the decision was based. If a written determination as to the request for review of the denied claim is not received by the end of the 60 day period (or 120 days if an extension is requested), the claim should be deemed denied on review. The decision on review of the Insurer/Claims Administrator will be final.

ERISA INFORMATION
(Continued)

PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Employer and any participant, nor to be consideration or an inducement for the employment of any participant or Employee. Nothing contained in this Plan shall be deemed to give any participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any participant or Employee at any time, subject to the terms of any applicable collective bargaining agreement, regardless of the effect which such discharge shall have upon him as a participant of this Plan.

STATEMENT OF ERISA RIGHTS:

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- (a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (b) Obtain copies of all documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the Plan's annual financial report. The Plan Administrator may be required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit or exercising your rights under ERISA. If your claim for a Welfare Benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquirers, Pension and Welfare Benefit Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.]



DELAWARE AMERICAN LIFE INSURANCE COMPANY
ONE ALICO PLAZA
WILMINGTON, DELAWARE 19801
(302) 594-2000
(Herein called the Insurance Company)

CERTIFICATE OF INSURANCE
for certain Employees of:

[XYZ NIGERIA]
([a Participating Employer] effective [August 1, 2006])

who are insured under Group Policy Number [xxxx]
issued to

[ABC Company]
(the Policyholder)

Delaware American Life Insurance Company hereby certifies that certain benefits provided by the Group Policy are available to Employees of the [Participating Employer] [Policyholder] who are in an Eligible Class. Under no circumstances may any insurance become effective prior to the Effective Date as determined in the section of this document entitled Effective Date of Insurance.

INTRODUCTION

ABOUT THIS CERTIFICATE. This Certificate describes group LTD insurance the Insurance Company provides to Insured Persons under the Group Policy (herein called "the Policy") issued to the Policyholder.

This document describes the coverage available under the Policy. It becomes an Employee's Certificate of Insurance only after he or she has met the eligibility requirements set forth in the section of this document entitled Eligibility for Insurance.

The coverage is funded through a Group Policy issued to the Policyholder by Delaware American Life Insurance Company.

The terms of the Policy that affect your insurance are contained in the following pages.

This Certificate of Insurance and the following pages will become your Certificate. This Certificate is a part of the Policy.

This Certificate replaces any other that the Insurance Company may have issued to the [Policyholder] [Participant Employer] to give to you under the Policy specified herein.

The President and Secretary of Delaware American Life Insurance Company witness this Certificate:

President

Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

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SCHEDULE OF BENEFITS

Eligible Employees: [All active, full-time [[US] Expatriate], [Third Country National] [and Key Local National] Employees of the Employer who normally work at least [30 hours per week.]]

[**Note:** [This plan covers only Employees [and their dependents] residing in the [country, countries] of [United Kingdom].] [The plan does not cover any Employees [and their dependents] residing in the [country, countries] of [Iraq].] [Any Employees [and their dependents] who return to the U.S.A. for more than [90 continuous days] will be terminated under the plan.]

Waiting Period
[LTD: [None]]

[[Open] [Annual] Enrollment Period: [Each November 1 succeeding the Policy Effective Date]
[Open Enrollment Effective Date: [January 1 following the Open Enrollment Period]]]

[LTD BENEFITS

- Age Limit [Age 65]
- Amount of Insurance [60%] of Basic Monthly Earnings
- Maximum Monthly Benefit [\$3,000]
- [Employer Pension Fund Contribution] [6%] of your Monthly Benefit
- [Employee Pension Fund Contribution] [6%] of your Monthly Benefit
- [National Insurance Contribution] [6%] of your Monthly Benefit
- Elimination Period [180 Days]
- Pre-Existing Conditions Limitation [3/12, 5 day, 6/12/24]
- [Benefit Duration] [To Age 65]]

**SCHEDULE OF BENEFITS
(Continued)**

[MAXIMUM DURATION OF BENEFITS TABLE

Age When [Totally] Disabled	Benefits Payable
Prior to Age 60	To Age 65 or for 60 months, if greater
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

If you are receiving or are eligible to receive benefits for a Disability under a prior disability plan that:

- (1) was sponsored by the Employer
- (2) was terminated before the Effective Date,

then no benefits will be payable for the Disability under the Policy.

The above table shows the maximum duration for which benefits may be paid. All other limitations of the Policy will apply.]

[Cost of Living Adjustment Benefit..... **Maximum Duration - Option A**
 5 Adjustments - Option B
 10 Adjustments - Option C

Adjustment Percentage **[1]%**

DEFINITIONS

["**Accidental Injury**"] means bodily Injury caused by an accident occurring while the Policy is in force with respect to the person whose Injury is the basis of a claim and resulting directly and independently of all other causes in a covered loss under the Policy. This includes related conditions and recurrent symptoms of such Injury.]

["**Acquired Immune Deficiency Syndrome**"] (AIDS) shall have the meanings assigned to it by the World Health Organization. The term opportunistic infection shall include but not be limited to Pneumocystis carini pneumonia, organism of chronic enteritis, virus and/or disseminated fungi infection. The term malignant neoplasm shall include but not be limited to Karposi's sarcoma, central nervous system lymphoma and/or other malignancies now known or which become known as immediate causes of death in the presence of acquired immune deficiency. Acquired Immune Deficiency Syndrome shall include H.I.V. (Human Immune Deficiency Virus), encephalopathy (dementia) and H.I.V. (Human Immune Deficiency Virus) wasting syndrome.]

["**Active Service**"] means an Employee will be considered in Active Service if he or she is performing in the customary manner all of the regular duties of his or her employment on a regularly scheduled work day at his or her usual place of employment or at some location to which the [Participating Employer's] [Policyholder's] business requires him or her to travel. An Employee will be considered in Active Service on a regularly scheduled non-work day if he or she was in Active Service on the immediately preceding scheduled work day.

Alternative 1-Similar occupation

["**Another Occupation**"] means the Insured is [totally] [partially] unable to perform each and every duty of his or her own occupation; is unable to perform any other gainful occupation for which he or she is reasonably suited by reason of education, training or experience; is not engaged in any occupation for remuneration or profit except for alternative occupations as set out under the Rehabilitative Employment; and you are under the regular care of a Physician but not necessarily confined in a Hospital.]

Alternative 2-Any occupation

["**Another Occupation**"] means the Insured is [totally] [partially] unable to perform any occupation; he or she is not engage in any occupation for remuneration or profit including alternative occupations as set out under the Rehabilitative Employment; and is under the regular car of a Physician but not necessarily confined in a Hospital.]

["**Basic Monthly Earnings**"] means the Insured's monthly rate of earnings from the Employer in effect just prior to the date Disability begins. It does not include overtime pay and other extra compensation. [It also does not include commissions and bonuses.]

[Commissions and/or bonuses received will be averaged for the lesser of:

- a. the 12 month period of employment just prior to the date Disability begins; or
- b. the period of employment.]]

["**Certificate**"] means a written statement prepared by the Insurance Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an Employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

["**Classification**"] or "**Earnings**" mean an Employee's Classification or Earnings as reported to the Insurance Company by the [Participating Employer] [Policyholder]. The [Participating Employer's] [Policyholder's] determination of the Classification or Earnings of an Employee will be considered conclusive.]

["**Creditable Coverage**"] means an Insured had prior coverage under: A group disability benefit plan or a disability benefit plan.

DEFINITIONS (Continued)

Version 1 - Long Term Income Protection

["Disability" and "Disabled"] mean that because of Injury or Sickness:

1. the Insured cannot perform each of the material duties of his or her Regular Occupation; or
2. the Insured, while unable to perform all of the material duties of his or her Regular Occupation on a full-time basis is:
 - a. performing at least one of the material duties of his or her Regular Occupation or Another Occupation on a part-time or full-time basis; and
 - b. earning currently at least 20% less per month than his or her Indexed Pre-Disability Earnings due to that same Injury or Sickness.

Version 2 - 24 month/residual

["Disability" and "Disabled"] mean that because of Injury or Sickness:

1. the Insured cannot perform each of the material duties of his or her Regular Occupation; and
2. after benefits have been paid for 24 months, the Insured cannot perform each of the material duties of Another Occupation; or
3. the Insured, while unable to perform all of the material duties of his or her Regular Occupation on a full-time basis is:
 - a. performing at least one of the material duties of his or her Regular Occupation or Another Occupation on a part-time or full-time basis; and
 - b. earning currently at least 20% less per month than his Indexed Pre-Disability Earnings due to that same Injury or Sickness.]

Version 3 – 24 month/partial

["Disability" and "Disabled"] mean that because of Injury or Sickness:

1. the Insured cannot perform each of the material duties of his or her Regular Occupation; and
2. after benefits have been paid for 24 months, the Insured cannot perform each of the material duties of Another Occupation.]

Use under either Version 1 or 2 or 3 of Disability definition for LTD

[Your failure to pass a physical examination required to maintain a license to perform the duties of your occupation does not alone mean that you are Totally Disabled. The loss of a license for any reason does not, in itself, constitute Disability.]

Alternative 2-Any occupation

[If any alternative occupation is taken, then the benefit payment will cease.]]

Version 4 – Long term own occupation

["Disability" and "Disabled"] mean that because of Injury or Sickness, the Insured cannot perform each of the material duties of his or her Regular Occupation.

Your failure to pass a physical examination required to maintain a license to perform the duties of your occupation does not alone mean that you are Totally Disabled. The loss of a license for any reason does not, in itself, constitute Disability.]

["Disability Benefits"], when used with the term Retirement Plan, means money which is payable under a Retirement Plan due to Disability as defined in that plan. However, if a Disability Benefit payment reduces the amount of money which would have been paid as a Retirement Benefit under the plan if the Disability had not occurred, then the Disability Benefit payment will be deemed a Retirement Benefit as defined in this policy.]

"Eligible Survivor" means the Insured's Spouse, if living, otherwise the Insured's children under age [25].

["Elimination Period" means a period of consecutive days of Disability for which no benefit is payable. The Elimination Period is shown in the Schedule of Benefits and begins on the first day of Disability.

For accumulating the Elimination Period, the following will apply:

1. The Disability will be treated as continuous if Disability stops during the Elimination Period for a total number of accumulated days which is not more than [14, 7, 5, 3] days or less.
2. Such days that the Insured is not Disabled will not count toward the Elimination Period.]

"Employee" means a full-time Employee of the [Participating Employer] [Policyholder], including Employees of one or more subsidiary corporations, and the Employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the Employer and such affiliated corporations, proprietorships or partnerships is under common control. Employee shall exclude, in any case, part-time Employees, temporary Employees and Employees who work for the [Participating Employer] [Policyholder] [less than the number of hours per week indicated in the Schedule of Benefits].

"Employer" means the [Policyholder] [Participant Employer].

"Evidence of Insurability" means a statement or medical evidence of health that determines if a person qualifies for coverage under the Policy.

"Expatriate" means an Employee who is working outside his or her country of permanent residence.

"Grace Period" is the 31 days following a premium due date during which premium payment may be made.

["Gross Monthly Benefit" means the Insured's benefit amount before any reduction for other income benefits and earnings.]

"Hospital" or "Institution" mean facilities licensed to provide care and treatment for the condition causing the Insured's Disability.

["Immediate Family" includes an Insured Person's Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), aunt, uncle, niece, nephew, or grandchild.]

["Indexed Pre-Disability Earnings" means the Insured's Basic Monthly Earnings in effect just prior to the date his or her Disability began adjusted on the first anniversary of benefit payments and each following anniversary. Each adjustment will be based on the littlest of 10% or the current annual percentage increase in the Consumer Price Index. The Consumer Price Index means a CPI or similar publication where available. The Insurance Company reserves the right to use some other similar measurement if the CPI ceases to be published.]

DEFINITIONS (Continued)

["**Injury**"] means bodily injury resulting directly from an accident and independently of all other causes. The Injury must occur and Disability must begin while the Employee is insured under this Policy.]

["**Insurance Company**"] means Delaware American Life Insurance Company. Any references to the terms "we", "us", and "our" will be deemed references to the Insurance Company.

["**Insured**"] means an Employee insured under this Policy.

["**Insured Employee**"] means an Employee for whom premium is paid while covered under the Policy.

["**Insured Person**"] means an Insured Employee [or an Insured Dependent].

["**Key Local National**"] means an Employee of the [Policyholder] [Participating Employer] working and residing within his or her country of permanent residence and who the [Policyholder] [Participating Employer] has designated as essential to the management of that country's operation.

["**Medicare**"] means the program of medical care benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as amended.]

["**Mental Illness**"] means Disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as: schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders, and/or adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions..]

["**Monthly Benefit**"] means the amount payable by the Insurance Company to the Disabled Insured.]

Used with either 24 month/partial or Long Term Own Occupation

["**Partial Disability**"] and ["**Partially Disabled**"] mean that because of Injury or Sickness the Insured, while unable to perform all of the material duties of his or her Regular Occupation on a full-time basis, is:

1. performing at least one of the material duties of his or her Regular Occupation or Another Occupation on a part-time or full-time basis; and
2. earning at least 20% less Basic Monthly Earnings per month than his or her Indexed Pre-Disability Earnings due to that same Injury or Sickness.]

["**Participating Employer**"] means an Employer who is part of a trust established to insure Employees of the Employer or any parent, subsidiary or its affiliated companies under a common control.]

["**Physician**"] means an individual who is operating within the scope of his or her license and is licensed to prescribe and administer drugs or to perform surgery. **Note:** For the purpose of the Policy, a duly licensed dentist, chiropractor, podiatrist or other practitioner acting within the scope of their licenses will be considered on the same basis as a Physician.

It will not include an Employee or his or her Spouse, daughter, son, father, mother, sister or brother.]

["**Policyholder**"] may be an Employer, including any parent, subsidy or affiliated company or the trust which the Employer created or participates in.

["**Pre-Existing Condition**"] means a Sickness or Injury for which the Insured received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the three months prior to the Insured's effective date.]

["**Pregnancy**"] includes miscarriage, abortion, childbirth or any complications thereof.]

DEFINITIONS (Continued)

"Recurrent Disability" means a Disability which is related to or due to the same cause(s) of a prior Disability for which a monthly benefit was payable.

"Regular Occupation" means the Insured is [totally] [partially] unable to perform each and every duty of his or her own occupation; is not engaged in any occupation for remuneration or profit except for alternative occupations as set out under the Rehabilitative Employment; and he or she is under the regular care of a Physician but not necessarily confined in a Hospital.

"Rehabilitative Employment" means employment that is part of a program of Vocational Rehabilitation. Any program of Rehabilitative Employment must be approved, in writing, by the Insurance Company.

["Residual Disability" and "Residually Disabled" mean you are prevented by:

- (1) accidental bodily Injury;
- (2) Sickness;
- (3) Mental Illness;
- (4) Substance Abuse; or
- (5) Pregnancy,

from performing some, but not all, of the essential duties of your [or any] occupation, and as a result your Current Monthly Earnings are at least [20%], but no more than [80%] of your [Indexed] Pre-Disability Earnings.]

["Retirement Benefit", when used with the term Retirement Plan, means money which:

1. is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
2. does not represent contributions made by an Employee; and

Note: Payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments are actually received.

3. is payable upon:
 - a. early or normal retirement; or
 - b. Disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the Disability had not occurred.]]

["Retirement Plan" means a plan which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), and a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

Employer's Retirement Plan is deemed to include any Retirement Plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
2. for which the Employee is eligible as a result of employment with the Employer or for which the Employee is eligible for from a union Retirement Plan.]

["Sickness" means any physical Sickness, Mental Illness, Substance Abuse or functional nervous disorder diagnosed by a Physician. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. [The term "Sickness" also includes Pregnancy [, except for the LTD benefits].]]

DEFINITIONS
(Continued)

["Spouse"] means the Insured Employee's lawful Spouse (not including a Spouse who is legally separated from the Insured).]

["Substance Abuse"] means the overindulgence in and dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health, or the welfare of others.]

["Third Country National"] means an Employee who works outside his or her country of permanent residence and outside the [Policyholder] [Participating Employer]'s country of domicile.

["Total Disability"] and **["Totally Disabled"]** mean that, as a result of Injury or Sickness, the Insured Employee is unable to engage in any occupation for which he or she is reasonably qualified by education, training or experience.]

["Total Covered Payroll"] is the total amount of Basic Monthly Earnings for which all Employees are insured under this Policy.]

["Waiting Period"], shown in the Schedule of Benefits, means the continuous length of time an Employee must serve in an eligible class to reach his eligibility date.

ELIGIBILITY FOR INSURANCE

EMPLOYEES

Each Employee in a class of Eligible Employees will become eligible for insurance on the date he or she completes the Waiting Period, if any. Any Waiting Period will be waived for an Employee previously insured under the Policy, whose insurance terminated for a reason other than cancellation of his or her payroll deduction order under the Policy, if the Employee becomes employed in one of the classes of Eligible Employees within one year after his or her insurance terminates. The classes of Eligible Employees and the Waiting Period are shown in the Schedule of Benefits.

EFFECTIVE DATE OF INSURANCE

EMPLOYEES

[Non-Contributory

If the [Participating Employer's] [Policyholder's] plan under the Policy or the coverage afforded there under is issued on a non-contributory basis, an Eligible Employee's coverage will become effective on the later of:

1. the effective date of the Policy; or
2. the date such Employee becomes eligible for coverage under the Policy.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

[Contributory

If the [Participating Employer's] [Policyholder's] plan under the Policy or any coverage afforded there under is issued on a contributory basis, each Employee may elect for such insurance by signing an enrollment form approved by the [Participating Employer] [Policyholder] and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the [Participating Employer] [Policyholder] on or before that date; or
2. the date on which the enrollment form is received by the [Participating Employer] [Policyholder], if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the [Participating Employer] [Policyholder] more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

[Open Enrollment. The Open Enrollment Period, shown in the Schedule, is a period of time agreed upon by the Policyholder and the Insurance Company, during which: (a) members of an Eligible Class may apply for insurance; and (b) Insureds may elect to make changes in their Amount of Insurance or apply for additional insurance. Any changes made during the Open Enrollment Period will take effect on the date shown in the Schedule. Any changes in the Amount of Insurance during the Open Enrollment will be limited to [one incremental increase]. All other increases will be subject to Evidence of Insurability]

[Annual Enrollment. The Annual Enrollment Period, shown in the Schedule, is a period of time during which any Eligible Insured's may apply for insurance or elect to make changes in their Amount of Insurance. Any changes in the Amount of Insurance during an Annual Enrollment will be limited to [one incremental increase]. Any increase either over the Guarantee Issue or more than the limited change amount will be subject Evidence of Insurability.]

INCREASES AND DECREASES IN AMOUNTS OF INSURANCE

Any increase in or addition to the benefits will take effect on the date of the change.

However, any such change applies only to on or after the effective date of the change.

If an Insured Employee is not in Active Service on the date the increase or addition is to take effect, it will take effect when he or she returns to Active Service.

Any decrease in or deletion of benefits will take effect on the date of the change.

TERMINATION OF INSURANCE

EMPLOYEES

An Insured Employee's coverage under the Policy will automatically terminate on the earliest of:

1. the date the Employee ceases to be in a class of Eligible Employees or ceases to qualify as an Employee;
2. the date the Employee's Employer ceases to be a [Participating Employer] [Policyholder] under the Policy;
3. the date the Policy is discontinued;
4. the last day for which any required contribution has been made;
5. [[90 days] after the date the Employee returns to the U.S to establish residency;]
6. the date the Employee ceases to be in Active Service, except as provided below:

Temporary Layoff or Leave of Absence. If an Employee's Active Service terminates because of temporary layoff or leave of absence, the insurance will be continued until the [Participating Employer] [Policyholder] ceases to pay premiums for the Employee or otherwise cancels the insurance. But in no event will the insurance be continued for more than [60 days] following termination of Active Service.

Any continuation of insurance must be in accordance with a plan which precludes individual selection.

[LTD BENEFITS

Disability

When the Insurance Company receives proof that an Insured is Disabled due to Sickness or Injury and requires the regular attendance of a Physician, the Insurance Company will pay the Insured a monthly benefit after the end of the Elimination Period. The benefit will be paid for the period of Disability if the Insured provides the Insurance Company with proof of continued:

1. Disability; and
2. regular attendance of a Physician.

The proof must be given upon request and at the Insured's expense.

The monthly benefit will not:

1. exceed the Insured's Amount of Insurance; nor
2. be paid for longer than the Benefit Duration.

The Amount of Insurance and the Benefit Duration are shown in the Schedule of Benefits.

Used with either 24 month Partial Disability or Long Term Own Occupation

[Partial Disability

When proof is received that an Insured is Partially Disabled within 31 days of the end of a period during which he or she received Disability Benefits the Insurance Company will pay a monthly benefit. The Partial Disability must result from the Injury or Sickness that caused the Disability.]

Monthly Benefit

Version 1 is standard plan

[To calculate the amount of monthly benefit:

1. Multiply the Insured's Basic Monthly Earnings by the benefit percentage shown in the Schedule of Benefits.
2. Take the lesser of the amount:
 - a. determined in step (1) above; or
 - b. the Maximum Monthly Benefit shown in the Schedule of Benefits, and
3. Deduct other income benefits, listed in this Policy, from this amount.]

Version 2 is All sources

[To calculate the amount of monthly benefit, take the lesser of:

1. The Insured's Basic Monthly Earnings multiplied by the benefit percentage shown in the Schedule of Benefits; or
2. The Insured's Basic Monthly Earnings multiplied by the all sources benefit percentage shown in the Schedule of Benefits, less other income benefits listed in this Policy; or
3. The Maximum Monthly Benefit shown in the Schedule of Benefits.]

But, if the Insured is earning more than 20% of his or her Indexed Pre-Disability Earnings in his Regular Occupation or Another Occupation, the following formula will be used to figure the monthly benefit.

LTD BENEFITS
(continued)

Partial Plus Non-standard

1. During the first 12 months, the monthly benefit will be figured as shown above, but it will not be reduced by any earnings until the Gross Monthly Benefit plus the Insured's earnings exceed 100% of his Indexed Pre-Disability Earnings. The monthly benefit will then be reduced by that excess amount.
2. After 12 months, the following formula will be used to figure the monthly benefit:]

$$(A \text{ divided by } B) \times C$$

Where:

- A = The Insured's "Indexed Pre-Disability Earnings" minus the Insured's monthly earnings received while he or she is Disabled.
- B = The Insured's "Indexed Pre-Disability Earnings".
- C = The benefit as figured above. This will not include adjustments under the Cost of Living Adjustment provision if included in this Policy.

Proof of the Insured's monthly earnings must be given to the Insurance Company on a quarterly basis. Benefit payments will be adjusted upon receipt of this proof of earnings.

[Other Income Benefits

Other income benefits mean the following:

1. The amount for which the Insured is eligible under:
 - a. Worker's or Workmen's Compensation Law;
 - b. occupational disease law; or
 - c. any other act or law of like intent.
2. The amount of any disability income benefits for which the Insured is eligible under any compulsory benefit act or law.
3. The amount of any disability income benefits for which the Insured [or his or her family] is eligible under:
 - a. any other group insurance plan;
 - b. any governmental retirement system as a result of his or her job with the Employer.
4. The amount of benefits from the Employer's Retirement Plan the Insured:
 - a. receives as Disability Benefits;
 - b. voluntarily elects to receive as Retirement Benefits; and/or
 - c. receives as Retirement Benefits when the Insured reaches the greater of age 62 or normal retirement age, as defined in the Employer's Retirement Plan.

As used here, "received" does not include any amount rolled over or transferred to any eligible Retirement Plan as that term is defined in Section 402 of the Internal Revenue Code of 1986 and any future amendments to Section 402 which affect the definition of an eligible Retirement Plan.

**LTD BENEFITS
(continued)**

Other Income Benefits (continued)

5. The amount of Disability or Retirement Benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, or any similar plan or act, as follows:
- a. Disability Benefits for which the Insured [or his or her family] is eligible;
 - b. Retirement Benefits received by the Insured [or his or her family].

These other income benefits, except Retirement Benefits, must be payable as a result of the same Disability for which this Policy pays a benefit.

[Item 5.b. will not apply to disabilities which begin after age 70 for those Insured's already receiving United States Social Security Retirement Benefits while continuing to work beyond age 70.]

Benefits under item 5.a. above will be estimated if such benefits:

- 1. have not been awarded; and
- 2. have not been denied; or
- 3. have been denied and the denial is being appealed.

The monthly benefit will be reduced by the estimated amount. But, these benefits will not be estimated provided that the Insured:

- 1. applies for benefits under item 5.a.; and
- 2. requests and signs the Insurance Company's Agreement Concerning Benefits.

This agreement states that the Insured promises to repay the Insurance Company any overpayment caused by an award received under item 5.a..

If benefits have been estimated, the monthly benefit will be adjusted when the Insurance Company receives proof:

- 1. of the amount awarded; or
- 2. that benefits have been denied and the denial is not being appealed.

In the case of 2. above, a lump sum refund of the estimated amounts will be made.

"Law", "plan", or "act" means the initial enactment and all amendments.]

Cost of Living Freeze

After the first deduction for each of the other income benefits, the monthly benefit will not be further reduced due to any cost of living increases payable under these other income benefits.

Lump Sum Payments

Other income benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the Insured's expected lifetime as determined by the Insurance Company.

LTD BENEFITS (continued)

Termination of Disability Benefits

Disability Benefits will cease on the earliest of:

1. the date you are no longer [Totally] Disabled;
2. the date you fail to furnish proof, when requested by us, that you continue to be [Totally] Disabled;
3. the date you refuse to be examined by a Physician, if we require such an examination;
4. the date you die;
5. [the date your Current Monthly Earnings exceed:
 - (a) [80%] of your [Indexed] Pre-Disability Earnings [if you are receiving benefits for being Disabled from your own occupation;] or
 - (b) an amount that is equal to your [Indexed] Pre-Disability Earnings multiplied by the Benefit Percentage [then in effect] if you are receiving benefits for being Disabled from any occupation;]]
6. [the date the Employer offers you another or modified job position, which Physicians agree you are able to perform, at a pay rate that exceeds [80%] of your [Indexed] Pre-Disability Earnings;]
7. [the date you refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;]
8. the [date] [age] determined from the Maximum Duration of Benefits Table shown in the Schedule of Benefits.
9. [the date you receive Retirement Benefits from any Employer's Retirement Plan, unless:
 - (a) you were receiving them prior to becoming Disabled; or
 - (b) you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;]]

Recurrent Disability

A Recurrent Disability will be treated as part of the prior Disability if, after receiving Disability Benefits under this Policy, an Insured:

1. returns to his or her Regular Occupation on a full-time basis for less than [six] months; and
2. performs all the material duties of his or her occupation.

Benefit payments will be subject to the terms of this Policy for the prior Disability.

If an Insured returns to his or her Regular Occupation on a full-time basis for [six] months or more, a Recurrent Disability will be treated as a new period of Disability. The Insured must complete the Elimination Period.

In order to prevent over insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to the Insured under any other group long term disability Policy.

Survivor Benefit

The Insurance Company will pay a benefit to the Eligible Survivor when proof is received that an Insured died:

1. after Disability had continued for [180] or more consecutive days; and
2. while receiving a monthly benefit.

The benefit will be an amount equal to [three] times the Insured's Gross Monthly Benefit.

If payment becomes due to the Insured's children, payment will be made to:

1. the children; or
2. a person named by the Insurance Company to receive payments on the children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

**LTD BENEFITS
(continued)**

Survivor Benefit (continued)

But, if there are no Eligible Survivors, payment will be made to the Insured's estate.

[RETURN TO WORK INCENTIVE

Version 1 for Partial

[Does the benefit calculation change if you return to limited duties after receiving benefits for Total Disability?

For Partial Disability, your Monthly Benefit for the 12 month period following the end of the Elimination Period will be calculated as follows:

- (1) Determine the Monthly Benefit that would be paid if Totally Disabled and add to it the amount of any Current Monthly Earnings;
- (2) if the sum from above exceeds your level of Pre-Disability Earnings, determine the amount of the excess by subtracting your Pre-Disability Earnings from the sum;
- (3) your Monthly Benefit will be the Monthly Benefit that would be paid if Totally Disabled minus the amount of the excess determined in item (2) above.

During this 12 month period, the sum of your Monthly Benefit and your Current Monthly Earnings may provide an amount up to 100% of your Pre-Disability Earnings.]

Version 2 for Residual

[How are benefits calculated if you return to limited duties during or following the Elimination Period?

For Residual Disability, your Monthly Benefit for the 12 month period following the end of the Elimination Period will be calculated as follows:

- (1) Determine the Monthly Benefit that would be paid if Totally Disabled and add to it the amount of any Current Monthly Earnings;
- (2) if the sum from above exceeds your level of Pre-Disability Earnings, determine the amount of the excess by subtracting your Pre-Disability Earnings from the sum;
- (3) your Monthly Benefit will be the Monthly Benefit that would be paid if Totally Disabled minus the amount of the excess determined in item (2) above.

During this 12 month period, the sum of your Monthly Benefit and your Current Monthly Earnings may provide an amount up to 100% of your Pre-Disability Earnings.]

How are benefits calculated after the 12th Monthly Benefit has been paid?

After you have received a Monthly Benefit for a 12 month period, and you continue to be [Partially/Residually] Disabled, the following calculation is used to determine your Monthly Benefit:

$$\text{Monthly Benefit} = \frac{\text{A} - \text{B}}{\text{A}} \times \text{C}$$

Where

- A** = Your [Indexed] Pre-Disability Earnings.
- B** = Your Current Monthly Earnings.
- C** = The Monthly Benefit payable if you were Totally Disabled.]

**LTD BENEFITS
(continued)**

Version 1 Use with no return to work incentive

[PARTIAL DISABILITY BENEFIT]

How are benefits calculated for Partial Disability?

If after you have received a Monthly Benefit for being Totally Disabled, you are able to perform some but not all the essential duties of your [or any] occupation, and are Partially Disabled, the following calculation is used to determine your Monthly Benefit:

$$\text{Monthly Benefit} = \frac{(A - B) \times C}{A}$$

Where

- A** = Your [Indexed] Pre-Disability Earnings.
- B** = Your Current Monthly Earnings.
- C** = The Monthly Benefit payable if you were Totally Disabled.

If you are participating in a program of Rehabilitative Employment approved by us, your Monthly Benefit will be determined by the Rehabilitative Employment Benefit.]

Version 2 with no return to work incentive

[RESIDUAL DISABILITY BENEFIT]

How are benefits calculated for Residual Disability?

If you are able to perform some but not all the essential duties of your [or any] occupation, and are Residually Disabled, the following calculation is used to determine your Monthly Benefit:

$$\text{Monthly Benefit} = \frac{(A - B) \times C}{A}$$

Where

- A** = Your [Indexed] Pre-Disability Earnings.
- B** = Your Current Monthly Earnings.
- C** = The Monthly Benefit payable if you were Totally Disabled.

Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits.

If you are participating in a program of Rehabilitative Employment approved by us, your Monthly Benefit will be determined by the Rehabilitative Employment Benefit.]

How is the benefit calculated for a period of less than a month?

If a Monthly Benefit is payable for less than a month, we will pay 1/30 of the Monthly Benefit for each day you were Disabled.

Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits, except as permitted in the right to recovery language in the General Provisions.

LTD BENEFITS
(continued)

[VOCATIONAL REHABILITATION

What Vocational Rehabilitative Services are available?

If you are Disabled, our Vocational Rehabilitative Services may help prepare you to resume gainful work.

Our Vocational Rehabilitative Services include, when we consider it appropriate, any necessary and feasible:

- (1) vocational testing;
- (2) vocational training;
- (3) work-place modification, to the extent not otherwise provided;
- (4) prosthesis; or
- (5) job placement.]

[REHABILITATIVE EMPLOYMENT

Do earnings from Rehabilitative Employment affect the Monthly Benefit?

If you are Disabled and are engaged in an approved program of Rehabilitative Employment, your Monthly Benefit will be:

- (1) the amount calculated for Total Disability; but
- (2) reduced by [50-70%] of the income received from each month of such Rehabilitative Employment.

The sum of the resulting net Monthly Benefit and your total income received under Rehabilitative Employment may not exceed 100% of your [Indexed] Pre-Disability Earnings. If it does, the net Monthly Benefit will be reduced by the amount of the excess.]

[EMPLOYER PENSION FUND CONTRIBUTION

A Pension Fund means a plan which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), and a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

To calculate the amount of monthly contribution multiply the Insured's monthly benefit by the percentage shown in the Schedule of Benefits. These funds will then be sent along each month to the Employer so can be contributed into the fund.]

[EMPLOYEE PENSION FUND CONTRIBUTION

A Pension Fund means a plan which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), and a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

To calculate the amount of monthly contribution multiply the Insured's monthly benefit by the percentage shown in the Schedule of Benefits. These funds will then be sent along each month to the Employer so can be contributed into the fund.]

LTD BENEFITS
(continued)

[NATIONAL INSURANCE CONTRIBUTION

National Insurance is a system of taxes, and related social security benefits, which has operated in the United Kingdom since its introduction in 1911, and wider extension by the government of Clement Attlee in 1946.

To calculate the amount of monthly contribution multiply the Insured's monthly benefit by the percentage shown in the Schedule of Benefits. These funds will then be sent along each month to the Employer so can be contributed into the plan.]

General Exclusions

This Policy does not cover any Disability due to:

- [1. war, declared or undeclared, or any act of war; or]
- [2. intentionally self-inflicted injuries; or]
- [3. active participation in a riot; or]
- [4. you are not under the Regular Care of a Physician; or]
- [5. Disability is caused by your commission of, or attempt to commit, a felony, or to which a contributing cause was your being engaged in an illegal occupation; or]
- [6. a Disability for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or]
- [7. your Disability is as a result of your doing any work for pay or profit for another Employer; or]
- [8. unless it is the result of a work-related Sickness or Injury sustained in the course of performing tasks for the Employer; or]
- [9. Acquired Immune Deficiency Syndrome (AIDS); or]
- [10. maternity except for complications; or]
- [11. Chronic Fatigue Syndrome; or]
- [12. Environmental Allergic or Reactive Illness; or]
- [13. musculoskeletal and connective tissue disorders of the neck and back; or]
- [14. mental illness or neuron-psychiatric diseases; or]
- [15. any disease that is not supported by medical objective findings and tests; or]
- [16. Post Traumatic Stress Syndrome].
- [17. radiological, nuclear, chemical or biological weapons or events]

Pre-Existing Conditions Exclusions

Version 1 3/12

[This Policy will not cover any Disability:

- a. caused by, contributed to by, or resulting from a Pre-Existing Condition; and
- b. which begins in the first 12 months after an Insured's effective date.]

Version 2 5 day

[This Policy will not cover any Disability:

- a. caused by, or contributed to by a Pre-Existing Condition; or
- b. resulting from a Pre-Existing Condition.

But, this Policy will cover that Disability once the Insured has performed the material duties of his occupation:

- a. on a full-time basis;
- b. for at least five consecutive days after the Insured's effective date.]

LTD BENEFITS
(continued)

Version 3 6/12/24

[This Policy will not cover any Disability:

- a. caused by, contributed to by, or resulting from a Pre-Existing Condition; and
- b. which begins before:

- (1) a period of 12 consecutive months starting on or after the Insured's effective date of coverage, during which the Insured has not received medical treatment, consultation, care or services including diagnostic measures, or taken prescribed drugs or medicines; or
- (2) 24 months after the Insured's effective date of insurance.]

[Any period of Creditable Coverage under a prior plan will be subtracted from the [twelve] month look back period if the insured can justify a similar insurance contract under the prior plan. However, if there has been a period of 30 days between the date coverage ended under such prior plan and the first day of any required Waiting Period under the Policy, any period of Creditable Coverage under such prior plan will *not* be subtracted from the [twelve] month look back period.]

Version 1

[Mental Illness Limitation

Benefits for Disability due to Mental Illness will not exceed 24 months of monthly benefit payments unless the Insured meets one of these situations.

- 1. The Insured is confined to a Hospital or Institution at the end of the 24 month period. The monthly benefit will continue during such confinement.

If the Insured is still Disabled when he or her is discharged, the monthly benefit will be paid for a recovery period of up to 90 days.

If the Insured becomes reconfined during the recovery period for at least 14 consecutive days, benefits will be paid for the confinement and another recovery period up to 90 days

- 2. The Insured continues to be Disabled and becomes confined:.

- a. after the 24 month period; and
- b. for at least 14 consecutive days.

The monthly benefit will be payable during the confinement.

The monthly benefit will not be payable beyond the maximum benefit period.

**LTD BENEFITS
(continued)**

This limitation does not apply to dementia, if due to:

1. stroke;
2. trauma;
3. viral infection;
4. Alzheimer's disease; or
5. other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.]

Version 2

[Mental Illness, Alcoholism and Drug Addiction Limitation

Benefits for Disability due to Mental Illness, alcoholism or drug addiction will not exceed 24 months of monthly benefit payments unless the Insured meets one of these situations.

1. The Insured is confined to a Hospital or Institution at the end of the 24 month period. The monthly benefit will continue during such confinement.

If the Insured is still Disabled when he or she is discharged, the monthly benefit will be paid for a recovery period of up to 90 days.

If the Insured becomes reconfined during the recovery period for at least 14 consecutive days, benefits will be paid for the confinement and another recovery period up to 90 days.

2. The Insured continues to be Disabled and becomes confined:
 - a. after the 24 month period; and
 - b. for at least 14 consecutive days.

The monthly benefit will be payable during the confinement.

The monthly benefit will not be payable beyond the maximum benefit period.

This limitation does not apply to dementia, if due to:

1. stroke;
2. trauma;
3. viral infection;
4. Alzheimer's disease; or
5. other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.]

LTD BENEFITS
(continued)

[Cost of Living Adjustment

Eligibility

An Insured will be eligible for cost of living adjustments on the first anniversary of benefit payments and each following anniversary. Adjustments may be made as long as the Insured is receiving benefits if option A is indicated in the Schedule of Benefits. If option B or C is indicated, then no more than the number of adjustments chosen may be made during the Insured's benefit period.

Adjustment Amount

The Insured's net monthly benefit will be increased by the percentage shown the Schedule of Benefits.

Each adjustment will be added to the Insured's net monthly benefit and will be paid monthly.

Maximum Monthly Benefit

Cost of living adjustment increases are not subject to the Maximum Monthly Benefit.

Net Monthly Benefit

The net monthly benefit means the amount determined by reducing the Insured's Amount of Insurance by other income benefits and any reductions for earnings. The net monthly benefit will be determined each month. For the purpose of calculating adjustments, the net monthly benefit will include any prior years' cost of living adjustments.]

Waiver of Premium

Premium payments for an Employee are waived during any period for which benefits are payable. Premium payments may be resumed following a period during which they were waived.

**LTD BENEFITS
(continued)**

[Continuity of Coverage Upon Transfer of Insurance Carriers

In order to prevent loss of coverage for an Employee because of a transfer of insurance carriers, this Policy will provide coverage for certain Employees as follows:

Failure to be in Active Employment Due to Injury or Sickness;

This Policy will cover, subject to premium payments, Employees:

1. insured with the prior carrier at the time of transfer; and
2. who are not in active employment due to Injury or Sickness.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

Disability Due to a Pre-existing Condition;

Benefits may be payable for a Disability due to a Pre-Existing Condition for an Employee who:

1. was insured by the prior carrier at the time of transfer; and
2. was in active employment and insured under this Policy on its effective date.

The benefit will be determined according to this Policy's benefit schedule if the Employee satisfies the Pre-Existing Conditions exclusion under:

1. this Policy; or
2. the prior carrier's policy, giving consideration towards continuous time insured under both policies.

The benefit will be determined according to this Policy's Schedule of Benefits, but will not exceed the prior carrier's Maximum Monthly Benefit. No benefit will be paid if the Employee cannot satisfy the Pre-Existing Condition exclusion of 1. or 2. above.]]

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Insurance Company within [30] days after the occurrence of the event on which the claim is based.

Written notice of claim given by or on behalf of the Insured Employee to the Insurance Company at its Home Office, or to any authorized agent of the Insurance Company, with particulars sufficient to identify the Employee, will be considered notice to the Insurance Company. Failure to give written notice within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as was reasonably possible.

Claim Forms. The Insurance Company, when it receives the notice of claim directly from the [Participating Employer] [Policyholder], will furnish to the [Participating Employer] [Policyholder] for delivery to the Employee or the Beneficiary, the claim forms which it usually furnishes for filing proof of loss. If the Employee or Beneficiary does not receive these claim forms within [15] days after receipt by the Insurance Company of the notice of claim, the Employee may submit any other written proof which fully describes the nature and extent of your claim.

Proof of Loss. Written proof of loss must be sent to us within 90 days after the start of the period for which we owe payment. After that, we may require further written proof that you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

- (1) it was not possible to give proof within the required time; and
- (2) proof is given as soon as possible; but
- [(3) not later than 1 year after it is due, unless you are not legally competent.]

We have the right to require, as part of the proof of loss:

- (1) your signed statement identifying all Other Income Benefits; and
- (2) proof satisfactory to us that you and your dependents have duly applied for all Other Income Benefits which are available.

After submitting proof of loss, you will be required to apply for U.S. Social Security Disability Benefits. If the U.S. Social Security Administration denies your eligibility for any such benefits, you will be required to follow the process established by the U.S. Social Security Administration to reconsider the denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

We reserve the right to determine if your proof of loss is satisfactory.

You will not be required to claim any Retirement Benefits which you may only get on a reduced basis.

Payment of Claims. If written proof of loss is furnished, accrued benefits will be paid at the end of each month that you are Disabled. If payment for a part of a month is due at the end of the claim, it will be paid as soon as written proof of loss is received.

All payments are payable to you. Any payments owed at your death may be paid to your estate. If any payment is owed to your estate, a person who is a minor or a person who is not legally competent, then we may pay up to \$1,000 to any of your relatives who are entitled to it in our opinion. Any such payment shall fulfill our responsibility for the amount paid.

Overpayments. We have the right to recover from you any amount that is determined to be an overpayment of benefits under the Policy. Repayment to us must be made within 60 days of your receipt of our notice of the amount of the overpayment. If you do not repay the overpayment within the 60 day period, we may, without forfeiting our right to collect an overpayment through any means legally available to us, recover all or any portion of the overpayment by reducing or withholding future benefit payments[, including the Minimum Monthly Benefit].

CLAIMS PROVISIONS
(continued)

Claim Notification. If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:

- (1) give the specific reason(s) for the denial;
- (2) make specific reference to the policy provisions on which the denial is based;
- (3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
- (4) provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to us for a full and fair review. You may:

- (1) request a review upon written application within 60 days of the claim denial;
- (2) review pertinent documents; and
- (3) submit issues and documents in writing.

We will make a decision no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific references to the policy provisions on which the decision is based.

GENERAL PROVISIONS

Legal Actions. No action at law or in equity will be brought to recover on the Policy prior to the expiration of [60] days after written proof of loss has been filed in accordance with the requirements of the Policy, nor will any action be brought at all unless brought within [three] years from the expiration of the time within which proof of loss is required by the Policy.

Time Limitations. If any time limitation provided in the Policy for giving notice of claims, for furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the jurisdiction in which the Employee resides at the time the Policy is issued, and then the time limitation of the prevailing jurisdiction applies.

Physical Examination and Autopsy. The Insurance Company, at its own expense, will have the right and opportunity to examine any individual for whom claim is pending under the Policy when and as often as it may reasonably require and to make an autopsy in case of death where it is not forbidden by law.

Reimbursement and Subrogation. When an Insured Person's Injury appears to be someone else's fault, benefits otherwise payable under the Policy for covered expenses incurred as a result of that Injury will not be paid unless the Insured Person or his legal representative agrees:

1. to repay the Insurance Company for such benefits to the extent they are for losses for which compensation is paid to the Insured Person by or on behalf of the person at fault;
2. to allow the Insurance Company a lien on such compensation and to hold such compensation in trust for the Insurance Company; and
3. to execute and give to the Insurance Company any instruments needed to secure the rights under (a) and (b).

Further, when the Insurance Company has paid benefits to or on behalf of the injured Insured Person, the Insurance Company will be subrogated to all rights of recovery that the Insured Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Insurance Company has paid. The Insured Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Insurance Company.

Policy Interpretation of terms and conditions. We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.



DELAWARE AMERICAN LIFE INSURANCE COMPANY

ONE ALICO PLAZA
WILMINGTON, DELAWARE 19801
(302) 594-2000
(Herein called the Insurance Company)

CERTIFICATE OF INSURANCE

for certain Employees of:

[XYZ NIGERIA]

([a Participating Employer] effective [August 1, 2006])

who are insured under Group Policy Number [xxxx]
issued to

[ABC Company]
(the Policyholder)

Delaware American Life Insurance Company hereby certifies that certain benefits provided by the Group Policy are available to Employees of the [Participating Employer] [Policyholder] who are in an Eligible Class. Under no circumstances may any insurance become effective prior to the Effective Date as determined in the section of this document entitled Effective Date of Insurance.

INTRODUCTION

ABOUT THIS CERTIFICATE. This Certificate describes group [medical] [, dental] [and] [vision] insurance the Insurance Company provides to Insured Persons under the Group Policy (herein called "the Policy") issued to the Policyholder.

This document describes the coverage available under the Policy. It becomes an Employee's Certificate of Insurance only after he or she has met the eligibility requirements set forth in the section of this document entitled Eligibility for Insurance.

The coverage is funded through a Group Policy issued to the Policyholder by Delaware American Life Insurance Company.

The terms of the Policy that affect your insurance are contained in the following pages.

This Certificate of Insurance and the following pages will become your Certificate. This Certificate is a part of the Policy.

This Certificate replaces any other that the Insurance Company may have issued to the [Policyholder] [Participant Employer] to give to you under the Policy specified herein.

The President and Secretary of Delaware American Life Insurance Company witness this Certificate:

President

Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

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SCHEDULE OF BENEFITS

Eligible Employees: [All active, full-time [[U.S.] Expatriate], [Third Country National] and [Key Local National] Employees of the Employer who normally work at least [30 hours per week.]]

[Note: [This plan covers only Employees [and their Dependents] residing in the [country, countries] of [United Kingdom].] [The plan does not cover any Employees [and their Dependents] residing in the [country, countries] of [Iraq].] [Any Employees [and their Dependents] who return to the U.S.A. for more than [90 continuous days] will be terminated under the plan.]

Waiting Period

[Medical: [None]]
[Dental: [None]]
[Vision: [None]]
[All Benefits: [None]]

[[Open] [Annual] Enrollment Period: [November 1 of each succeeding year]
[Open Enrollment Effective Date: [January 1 following the Open Enrollment Period]]]

[MEDICAL BENEFITS

Classification

[All Eligible Employees [and their Dependents]]

[Preferred Provider Network

The Preferred Provided Network is an arrangement in which a network of Hospitals and Physicians have agreed to provide medical care services to Insured Persons. The Preferred Provided Network is for expenses incurred in the [U.S.A. only]. The Hospitals and Physicians will provide these services according to negotiated fee schedules that are considered full payment for services rendered subject to the plan provisions. An Insured Person has the option to utilize an In-Network or an Out-of-Network provider. Benefits applicable to both types of providers are shown below.

For treatment or care received outside any In-Network geographic service area, benefits for Covered Medical Expenses will be payable at Out-of-Network levels. **However, if treatment is received in an Out-of-Network facility on an involuntary basis (such as loss of consciousness as a result of an Emergency Medical Condition), benefits for Covered Medical Expenses will be payable at In-Network levels.**

For treatment or care received for which there is no contracted In-Network provider, benefits for Covered Medical Expenses will be provided at the In-Network level.

For treatment or care rendered by a radiologist, anesthesiologist or pathologist, the applicable percentage payable will be based on the facility in which the care is received.]

Medical Deductibles

Individual Medical Deductible Per Insured Person

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[\$100]	[\$250]	[\$100]	[\$250]]

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

[Family Medical Deductible

<u>[In-Network U.S.]</u>	<u>[Out-of-Network U.S.]</u>	<u>[In-Network Non-U.S.]</u>	<u>[Out-of-Network Non-U.S.]</u>
[\$300]	[\$750]	[\$300]	[\$750]

[Air Ambulance Deductible Per Insured Person - [per occurrence] [\$ 200]]

[In-patient Hospital Deductible Per Insured Person_- [per occurrence] [\$ 200]]

- [NOTES: 1. Charges used to satisfy Deductibles for Covered Medical Expenses incurred in the U.S.A. will [not] be credited to the deductible for Covered Medical Expenses incurred outside the U.S.A..
2. Charges used to satisfy Deductibles for Covered Medical Expenses incurred outside the U.S.A. will [not] be credited to the Deductible for Covered Medical Expenses incurred in the U.S.A..
- [3. Charges used to satisfy Deductibles for Covered Medical Expenses incurred for treatment by In-Network providers will [not] be credited to the Deductible for Covered Medical Expenses incurred for treatment by Out-of-Network providers.
4. Charges used to satisfy Deductibles for Covered Medical Expenses incurred for treatment by Out-of-Network providers will [not] be credited to the Deductible for Covered Medical Expenses incurred for treatment by In-Network providers.]]

[Co pays – Apply only to services indicated below [which have been incurred in the U.S.A.]. After the Co pays the balance is payable at 100% coinsurance.

	<u>[In-Network]</u>	<u>[Out-of Network]</u>
1. For Physician Services [incurred in the U.S.A.] - [per visit]	[\$10]	[Ded/Coins.]
2. For Office Visits [incurred in the U.S.A.] - [per visit]	[\$10]	[Same as network if emergency.]
3. For Outpatient Psych Services [incurred in the U.S.A.] - [per visit]	[\$10]	[Ded/Coins.]
4. For Emergency Services [incurred in the U.S.A.] - [per visit]	[\$50]	[Ded/Coins.]
5. For Urgent Care Center [incurred in the U.S.A.] - [per visit]	[\$50]	[Ded/Coins.]
6. For Specialist Office Visit [incurred in the U.S.A.] - [per visit]	[\$10]	[Ded/Coins.]]

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Out-of-Pocket Maximums - [This provision does not apply to charges for [Treatment of Mental Illness and/or Substance Abuse,] [Prescription Drug charges,] [or] [to charges for Air Ambulance service.]] The Deductible is [NOT] included in the Out-of-Pocket Maximum.]

Individual Out-of Pocket Maximum Per Insured Person

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[\$1,000]	[\$2,500]	[\$1,000]	[\$2,500]

[Family Out-of Pocket Maximum

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[\$3,000]	[\$7,500]	[\$3,000]	[\$7,500]

- [NOTES: 1. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred in the U.S.A. will [not] be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred outside the U.S.A..
2. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred outside the U.S.A. will [not] be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred in the U.S.A..
- [3. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by In-Network providers will [not] be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by Out-of-Network providers.
4. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by Out-of-Network providers will [not] be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by In-Network providers.

Percentage Payable

[Outpatient Treatment of Serious Mental Illness and/or Substance Abuse

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% after deductible]	[70% after Deductible]	[50% after Deductible]	[50% after Deductible]

[Inpatient Treatment of Serious Mental Illness and/or Substance Abuse

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% after deductible]	[70% after Deductible]	[100% after Deductible]	[100% after Deductible]

[Outpatient Treatment of Mental Illness

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% after deductible]	[70% after Deductible]	[100% after Deductible]	[100% after Deductible]

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Percentage Payable (continued)

[Inpatient Treatment of Mental Illness]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% after deductible]	[70% after Deductible]	[100% after Deductible]	[100% after Deductible]

[Well Baby/Child Care]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

[Adult Preventive Care]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

[Mammogram Expenses]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

[Prostate Cancer Screenings]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

[Gynecological Exams]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

[Colonoscopy Expenses]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Percentage Payable (continued)

[Lead Screenings]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]]

[Immunizations]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]]

[Diabetic Supplies]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[100% Deductible waived]	[70% after Deductible]	[100% Deductible waived]	[100% Deductible waived]

[Hospital, Surgical and other Covered Medical Expense]

[In-Network U.S.]	[Out-of-Network U.S.]	[In-Network Non-U.S.]	[Out-of-Network Non-U.S.]
[90% after Deductible]	[70% after Deductible]	[100% after Deductible]	[100% after Deductible]]

[However, Deductibles will be waived for expenses incurred in connection with an Accidental Injury that results in an Emergency Medical Condition.]

[All inpatient Hospital Confinements in the U.S.A. [and air ambulance service anywhere] must be pre-certified. See page [29] for details and penalties for non-compliance.]

[Maternity/Obstetrical Charges]

Covered the same as any other condition.]

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

PRESCRIPTION DRUG BENEFITS

Classification

[All Eligible Employees [and their Dependents]]

[Deductibles]

**[U.S. In-Network Retail Pharmacy
[\$100]]**

**[Non U.S. In-Network Retail Pharmacy
[\$100]]**

**[U.S. Non-Network Retail Pharmacy
[\$200]]**

**[Non U.S. Non-Network Retail Pharmacy
[\$200]]**

**[U.S. Mail Service Network Pharmacy
[\$300]]**

**[Non U.S. Mail Service Network Pharmacy
[\$300]]**

[Co-payments]

[Network Retail Pharmacy]	
[Generic Drug]	[\$5 - \$30]
[Brand Name Drug on Preferred Drug List]	[\$5 - \$30]
[Brand Name Drug not on Preferred Drug List]	[\$5 - \$30]
[Mail Service Network Pharmacy]	
[Generic Drug]	[\$0 - \$30]
[Brand Name Drug on Preferred Drug List]	[\$0 - \$30]
[Brand Name Drug not on Preferred Drug List]	[\$0 - \$60]

[Coinsurance]

**[U.S. Network Retail Pharmacy
[80%] Coinsurance [not] subject to Medical Deductible]**

**[Non U.S. Network Retail Pharmacy
[80%] Coinsurance [not] subject to Medical Deductible]**

**[U.S. Non-Network Retail Pharmacy
[80%] Coinsurance [not] subject to Medical Deductible]**

**[U.S. Non-Network Retail Pharmacy
[80%] Coinsurance [not] subject to Medical Deductible]**

**[U.S. Mail Service Network Pharmacy
[80%] Coinsurance [not] subject to Medical Deductible]**

**[U.S. Mail Service Network Pharmacy
[80%] Coinsurance [not] subject to Medical Deductible]**

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Maximum Benefits

Lifetime Maximum Benefit Per Insured Person	[\$1,000,000]
[Lifetime Nursing Services Maximum Per Insured Person	[\$ 25,000]]
[Outpatient Mental Illness Maximum Per Insured Person.....	[30] visits per [calendar] [plan] year]
[Inpatient Mental Illness Maximum Per Insured Person.....	[30] days per [calendar] [plan] year]
[Inpatient Mental Illness Maximum Per Insured Person.....	[45] days per Lifetime]
[Well-Baby/Child Care Maximum	[Five] visits during the first year after birth and [one] visit per year for the following [five] years. [[\$400] [calendar] [plan] year maximum for [all] [each] Dependent Children [in any one family].]
[Adult Preventative Care Maximum	[\$[400] [calendar] [plan] year maximum for [all] [each] Dependent [in any one family][, including the Employee].]
[Durable Medical Equipment Maximum Benefit Per Insured Person	[\$50,000] per Lifetime]
[Podiatry Maximum Visits Per Insured Person	[10] visits per [calendar] [plan] year]
[Temporomandibular Joint Dysfunction Lifetime Maximum Per Insured Person	[[[\$2,500] Surgical treatment [\$500] Non-surgical treatment]]
[Treatment of Infertility Maximum Per Insured Person	[\$2,500] per Lifetime]
[Prescription Drugs Maximum Per Insured Person	[\$1,000] per [calendar] [plan] year]
[Orthoptic Training Maximum Visits Per Insured Person	[20] visits per [calendar] [plan] year]
[Physical/Occupational Therapy Maximum Visits Per Insured Person	[[20] visits per [calendar] [plan] year]]
[Speech Therapy Maximum Visits Per Insured Person.....	[[20] visits per [calendar] [plan] year]]
[Spinal Manipulation/Acupuncture/Acupressure Maximum Visits Per Insured Person [combined]	[[10] visits per [calendar] [plan] year]]
[Ambulance Service Maximums	
Local Land Transportation - [per occurrence]	[\$ 200]
[Air Ambulance Transportation - [per occurrence]	[\$ 2,500]]
[Limit on Air Ambulance Transportation	[One] trip per Insured Person per [calendar] [plan] year]]

**SCHEDULE OF BENEFITS
(Continued)**

MEDICAL BENEFITS (continued)

Maximum Benefits (continued)

- [Home Health Care Maximums Per Insured Persons [[40] visits per [calendar] [plan] year]]
- [Skilled Nursing Facility Maximums Per Insured Persons..... [60] days per [calendar] [plan] year]
- [Inpatient Physical Rehabilitation Facility Maximums Per Insured Persons.... [120] days per [calendar] [plan] year]
- [Hospice Care Lifetime Maximum Per Insured Persons [\$10,000]]
- Scalp Hair Prosthesis Maximum Per Insured Person.....\$500 per [calendar] [plan] year
- Hearing Aid Maximum Per Insured Person.....\$1,000 per ear
- [Daily Hospital Room and Board
Limit The Hospital's average daily rate for semi-private accommodations [up to a maximum of [\$150]]. However, the limit for charges for confinement in an intensive care unit will be [two] times the Hospital's average daily rate for semi-private accommodations [or if In-Network, will be the same as the Semi-Private room rate]]]

**SCHEDULE OF BENEFITS
(Continued)**

[DENTAL BENEFITS]

Classification

[All Eligible Employees [and their Dependents]]

Percentage Payable

Part I (Preventive) Expense	[100%]
Part II (Basic) Expense	[80%]
Part III (Major) Expense	[50%]
[Orthodontics [(for Dependent Children up to age 19)]]	[50%]]

Dental Deductible

Individual Dental Deductible (per [calendar] [plan] year) Per Insured Person	[\$ 50]
[Family Dental Deductible (per [calendar] [plan] year)	[\$100]]
<i>[The Dental Deductible does not apply to Part I (Preventive) Expense.]</i>	
[Orthodontic Deductible (per lifetime)	[\$ 50]]

Maximum Benefits

[Calendar] [Plan] Year Maximum Benefit Per Insured Person	[\$1,000]
[Lifetime Orthodontic Maximum Per Insured Person.....	[\$1,000]]

[VISION CARE BENEFITS]

Classification

[All Eligible Employees [and their Dependents]]

Schedule of Vision Care Services and Supplies

Percentage Payable

Vision Examination.....	[100%]
Lens	[100%]
Frames.....	[100%]

Services and Supplies

Maximum Allowance Per Insured Person

Vision Examination	[\$ 25.00]
Materials	
[Single Vision Lens	[\$ 20.00 per lens]
Bi-focal Lens.....	[\$ 40.00 per lens]
Tri-focal Lens.....	[\$ 50.00 per lens]
Contact Lens	[\$ 40.00 per lens]
Ventricular Lens	[\$ 60.00 per lens]
Frames	[\$ 20.00]]

DEFINITIONS

["**Accidental Injury**"] means bodily Injury caused by an accident occurring while the Policy is in force with respect to the person whose Injury is the basis of claim and resulting directly and independently of all other causes in a covered loss. This includes related conditions and recurrent symptoms of such Injury.】

["**Acquired Immune Deficiency Syndrome**"] (AIDS) shall have the meanings assigned to it by the World Health Organization. The term opportunistic infection shall include but not be limited to Pneumocystis carini pneumonia, organism of chronic enteritis, virus and/or disseminated fungi infection. The term malignant neoplasm shall include but not be limited to Karposi's sarcoma, central nervous system lymphoma and/or other malignancies now known or which become known as immediate causes of death in the presence of acquired immune deficiency. Acquired Immune Deficiency Syndrome shall include H.I.V. (Human Immune Deficiency Virus), encephalopathy (dementia) and H.I.V. (Human Immune Deficiency Virus) wasting syndrome.】

["**Acupressure or Acupuncture**"] seeks to remedy illness through either the application of deep finger pressure or needles at points located along an invisible system of energy channels called meridians.】

["**Active Service**"] An Employee will be considered in Active Service if he or she is performing in the customary manner all of the regular duties of his or her employment on a regularly scheduled work day at his or her usual place of employment or at some location to which the [Participating Employer's] [Policyholder's] business requires him or her to travel. An Employee will be considered in Active Service on a regularly scheduled non-work day if he or she was in Active Service on the immediately preceding scheduled work day.

["**Brand Name Drug**"] is a Prescription Drug which is (1) manufactured and marketed under a trademark or name by a specific drug manufacturer; and (2) identified as a Brand Name Drug by the Insurance Company.】

["**Certificate**"] means a written statement prepared by the Insurance Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an Employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

["**Covered Dental Injury**"] means an Injury caused by a sudden and violent external force. The Injury must be unexpected and unavoidable. A chewing Injury is not a Covered Dental Injury.】

["**Covered Emergency Evacuation Expense(s)**"] means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.】

["**Co-payment**"] is a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as \$10 or \$15 Co-payment per office visit). Co-payments, if any, are identified in the Schedule of Benefits.】

["**Creditable Coverage**"] means an Insured had prior coverage under: A group health benefit plan; A health benefit plan; Part A or Part B of Title XVIII of the U.S. Social Security Act; Title XIX of the U.S. Social Security Act; Chapter 55 of Title 10, United States Code; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; A health plan offered Chapter 89 of Title 5, United States Code; A public health plan as defines in federal regulations; or A health benefit plan under the Peace Corps Act.

DEFINITIONS (Continued)

["Custodial Care"] means care or services which are not intended primarily to treat a specific Injury or Sickness (including Mental Illness and/or Substance Abuse). Custodial Care includes, but is not limited to:

1. services related to watching or protecting a person
2. services related to performing or assisting a person in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting into or out of bed, toileting, eating, preparing foods or taking medications that can usually be self administered; and
3. services not required to be performed by trained or skilled medical or paramedical personnel.]

["Dentist"] means a person other than an Insured Person who: (a) is licensed to practice Dentistry; and (b) practices within the scope of his or her license. A dental hygienist, denturist or Physician will be considered a Dentist when he or she performs any dental service that is within the scope of his or her license.]

["Dental Treatment Plan"] means the Dentist's report of recommended treatment on a form accepted by the Sponsor that: (a) itemizes the dental procedures and charges required for the necessary care of the mouth; (b) lists the charges for each procedure; and (c) is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials required by the Insurance Company.]

["Dependent"] means an Employee's [Spouse] [who does not reside in the U.S.], [Domestic Partner] [who does not reside in the U.S.][or][Dependent Child [who does not reside in the U.S.]].]

["Dependent Child"] or **["Dependent Children"]** mean any unmarried child(ren) of the Employee, including a natural, step, foster or adopted child(ren) who is:

1. under [19] years of age; [(special provisions apply to children under 15 days of age - see General Medical Limitations);]
2. 19 years but under [23] years of age, if attending an accredited institution of higher learning on a full time basis) and primarily dependent on the Insured Employee for support and maintenance; or
3. 19 years of age or over and mentally or physically incapable of earning a living and primarily supported by the Insured Employee, provided the Insured Employee submits proof of the child's incapacity and dependency to the Insurance Company within 60 days before the date the Dependent Child fails to qualify under (1) or (2) above. If the Insured Employee fails to furnish the requested proof before the Dependent Child reaches the age limit, coverage for the Dependent Child will not be extended past the age limit. If coverage is extended, the Insurance Company may request that the Insured Employee submit satisfactory proof of the Dependent Child's continued incapacity and dependency to the Insurance Company on an annual basis. If the Insured Employee fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child will terminate at the end of that 31-day period.]

DEFINITIONS (Continued)

["Domestic Partner"] means an opposite or same sex partner who has met all of the following requirements for at least [12] consecutive months: (a) resides with the Insured Person at the same permanent residence; (b) is not married to the Insured Person under either statutory or common law; (c) is not related by blood to the Insured Person to a degree of closeness that would prohibit a legal marriage in the jurisdiction in which they reside; (d) is at least the age of consent in the jurisdiction in which they reside; (e) neither the Insured Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner and (f) is financially interdependent with the Insured Person and has provided the [Participating Employer] [Policyholder] with at least two (2) of the following documents evidencing such financial interdependence:

- joint ownership of real property or a common leasehold interest in real property
- common ownership of an automobile
- joint bank account
- a will in which one partner designates the other as primary beneficiary
- a beneficiary designation form for a retirement plan, or life insurance policy signed and completed to the effect that one partner is the primary beneficiary of the other
- if the Insured Person and Domestic Partner reside in a jurisdiction which provides for registration of Domestic Partners, they have so registered and provided the [Participating Employer] [Policyholder] with evidence of such registration.

The Insurance Company also requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.]

["Durable Medical Equipment"] means equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of Sickness or Injury; and (d) is appropriate for use in the home.]

["Emergency Evacuation"] means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness: (1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.]

["Emergency Sickness"] means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place their life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom.]

["Employee"] means a full-time Employee of the [Participating Employer] [Policyholder], including Employees of one or more subsidiary corporations, and the Employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the Employer and such affiliated corporations, proprietorships or partnerships is under common control. Employee shall exclude, in any case, part-time Employees, temporary Employees and Employees who work for the [Participating Employer] [Policyholder] [less than the number of hours per week indicated in the Schedule of Benefits].

["Employer"] means the [Policyholder] [Participant Employer].

["Evidence of Insurability"] means a statement or medical evidence of health that determines if a person qualifies for coverage under the Policy.

["Expatriate"] means an Employee who is working outside his country of permanent residence.

DEFINITIONS (Continued)

["Free-Standing Surgical Facility"] means an institution which is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions and which: (a) has a medical staff including Physicians, Registered Graduate Nurses and licensed anesthesiologists; (b) maintains at least two operating rooms and one recovery room, diagnostic X-ray and laboratory facilities, equipment for emergency care, a blood supply and medical record-keeping facilities; and (c) has agreements with Hospitals for immediate acceptance of patients requiring Hospital Confinement on an inpatient basis.]

["Generic Drug"] is a Prescription Drug which is: (1) chemically equivalent to a Brand Name Drug whose patent has expired; and (2) identified as a Generic Drug by the Insurance Company.]

["Grace period"] is the 31 days following a premium due date during which premium payment may be made.

["Home Health Aide"] means a certified or trained professional who provides services through a Home Health Care Agency which:

1. are not required to be performed by an RN, LPN or LVN;
2. primarily aid the Insured Person in performing the normal activities of daily living while recovering from an Injury or Sickness; and
3. are described under the Home Health Care Plan.]

["Home Health Care Agency"] means an agency or organization that:

1. is licensed, if required, by the appropriate licensing body to provide home health services and supplies;
2. is primarily engaged in nursing and other therapeutic services;
3. has its policies set up by professionals associated with the agency.]

["Home Health Care Plan"] means a program for continued health care and treatment in the Insured Person's home. It must either (a) follow within 24 hours of and be for the same or related cause(s) as a period of Hospital or Skilled Nursing Facility confinement; or (b) be in lieu of a Hospital or Skilled Nursing Facility confinement. It must be set up, approved in writing and renewed every 60 days by a Physician. Such Physician must certify that the proper treatment would require confinement as an inpatient in a Hospital or Skilled Nursing Facility if the services and supplies were not provided under a Home Health Care Plan. The Physician must also examine the Insured Person at least once a month.]

["Hospice"] means a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent Hospice administration and it helps the patient cope with physical, psychological, spiritual, social and economic stresses. The Hospice administration must meet the standards of the National Hospice Organization and any licensing requirements.]

["Hospice Benefit Period"] means a period that begins on the date the attending Physician certifies that the Insured Person is a terminally ill patient who has less than six months to live. It ends after six months (or such later period for which treatment is certified) or on the death of the Insured Person, if sooner.]

DEFINITIONS (Continued)

["Hospice Care Expenses"] are the Reasonable and Customary Charges made by a Hospice for the following services or supplies:

1. charges for inpatient care;
2. charges for drugs and medicines;
3. charges for part-time nursing by an RN, LPN or LVN;
4. charges for physical and respiratory therapy in the home;
5. charges for the use of medical equipment;
6. charges for visits by licensed or trained social workers, Psychologists or counselors;
7. charges for bereavement counseling of the Insured Person's Immediate Family prior to, and within three months after the Insured Person's death.
8. charges for respite care for up to five days in any 30 day period;

The term "respite care" means care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill Insured Person.】

["Hospital"] means (a) an institution constituted, licensed and operated in accordance with the laws pertaining to Hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of Injury and Sickness, and which provides such treatment for compensation, by or under the supervision of Physicians, on an inpatient basis with continuous 24-hour nursing service by Registered Graduate Nurses; or (b) an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare and is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals; or (c) an institution which specializes in treatment of Mental Illness, alcoholism, drug addiction or other related illness and which provides residential treatment programs, but only if that institution is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions. The term Hospital will also include a Free-Standing Surgical Facility but will not include an institution which is, other than incidentally, a place for rest, a place for the aged, or a nursing home.】

["Hospital Confinement"] or **["Confined In a Hospital"]** an individual will be considered Confined in a Hospital if he or she is a registered bed patient in a Hospital upon the recommendation of a Physician or is an outpatient in a Hospital because of (a) surgery; (b) emergency care of an Injury within 48 hours after the Injury is received; or (c) tests ordered by a Physician as a planned preliminary to inpatient admission to the same Hospital within four days. In addition, an individual will be considered Confined in a Hospital during partial confinement for treatment of Mental Illness, Substance Abuse or other related illness.

For the purpose of determining the benefits payable, two days of partial confinement in a Hospital will be considered one day of Hospital Confinement. Partial confinement means continuous treatment for at least three hours but not more than 12 hours in any 24-hour period.】

["Immediate Family"] includes an Insured Person's Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), aunt, uncle, niece, nephew, or grandchild.】

["Infertility"] means the presence of a demonstrated condition recognized by a license Physician and surgeon as a cause of Infertility; or the inability to conceive a Pregnancy or carry a Pregnancy to a live birth after a year or more of sexual relations without contraception.】

["Injury"] means bodily injury resulting directly from an accident and independently of all other causes. The Injury must occur and disability must begin while the Employee is insured under this policy.】

["Insurance Company"] means Delaware American Life Insurance Company. Any references to the terms "we", "us", and "our" will be deemed references to the Insurance Company.

["Insured"] means an Employee insured under this Policy.

DEFINITIONS (Continued)

["Insured Dependent"] means an Insured Dependent Child or an Insured Spouse, for whom premium is paid while covered under the Policy.]

["Insured Dependent Child" or "Insured Dependent Children"] mean the Employee's Dependent Child(ren), for whom premium is paid while covered under the Policy.]

"Insured Employee" means an Employee for whom premium is paid while covered under the Policy.

"Insured Person" means an Insured Employee [or an Insured Dependent].

["Insured Spouse"] means the Employee's Spouse, for whom premium is paid while covered under the Policy.]

"Key Local National" means an Employee of the [Policyholder] [Participating Employer] working and residing within his country of permanent residence and who the [Policyholder] [Participating Employer] has designated as essential to the management of that country's operation.

"Late Entrant" means an Employee [or Dependent] who enrolls for contributory coverage more than 30 days after his or her eligibility date.

["Medically Necessary"] means that a service or supply is determined by the Insurance Company to be medically appropriate and: (a) necessary to meet the basic health needs of the Insured Person, (b) rendered in the most cost-efficient manner and type of setting appropriate for delivery of the service or supply, (c) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or governmental agencies that are accepted by the Insurance Company, (d) consistent with the diagnosis of the condition, (e) required for reasons other than the convenience of the Insured Person or his or her Physician. The service or supply must also be demonstrated through prevailing peer-review medical literature to be either: safe and effective for treating or diagnosing the Injury or Sickness for which their use is proposed, or safe with promising efficacy (i) for treating a life threatening Injury or Sickness, (ii) in a clinically controlled research setting, and (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

For purposes of this definition, "life threatening" means an Injury or Sickness which is more likely than not to cause death within one year of the date of request for treatment.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury or Sickness does not mean that it is Medically Necessary. The definition of Medically Necessary as used in the Policy relates only to the insurance provided by the Policy and may differ from the way a Physician may define medical necessity.

With respect to confinement in a Hospital as an inpatient, "Medically Necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.]

["Medically Necessary Emergency Evacuation Service"] means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.]

["Medicare"] means the program of medical care benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as amended.]

["Mental Illness"] means any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors. Also called emotional illness, mental/nervous disorder and psychiatric disorder.]

DEFINITIONS (Continued)

["Miscellaneous Services and Supplies" includes any charges, other than charges for Room and Board, made by a Hospital on its own behalf for necessary medical confinement. Miscellaneous Services and Supplies will also include any charges, by whomever made, for professional ambulance services to or from the nearest Hospital where the medical care and treatment necessary for the individual can be provided, and any charges, by whomever made, for the administration of anesthetics during the Hospital Confinement, but will not include any charges for special nursing fees, dental fees or medical fees.]

["Network Pharmacy" is a pharmacy, which has (1), entered into an agreement with the Insurance Company or its designee to provide Prescription Drugs to Insured Persons; (2) has agreed to accept specified reimbursement rates for dispensing Prescription Drugs and (3) has been designated by the Insurance Company as a Network Pharmacy. A Network Pharmacy can be either Retail or a Mail Service Pharmacy.]

["Participating Employer" means an Employer who is part of a trust established to insure Employees of the Employer or any parent, subsidiary or its affiliated companies under a common control.]

["Physician" means an individual who is operating within the scope of his or her license and is licensed to prescribe and administer drugs or to perform surgery. **Note:** For the purpose of the Policy, a duly licensed Dentist, chiropractor, podiatrist or other practitioner acting within the scope of their licenses will be considered on the same basis as a Physician to the extent that the services are covered under the Policy.

It will not include an Employee or his or her Spouse, daughter, son, father, mother, sister or brother.]

["Podiatry" treatment is dedicated to the diagnosis, treatment and prevention of disease and disorders affecting the foot, ankle and lower extremities.]

"Policyholder" may be an Employer, including any parent, subsidy or affiliated company or the trust which the Employer created or participates in.

"Pre-existing Condition" is an Injury or Sickness for which the Insured received medical treatment, consultation, care or services including diagnostics measures, or had taken prescribed drugs or medicines in the [three months] prior to the Insured's effective date.

["Preferred Drug List" is a list of drugs selected as providing the highest therapeutic and economic value in their classes.]

["Pregnancy" includes miscarriage, abortion, childbirth or any complications thereof.]

["Prescription Drugs" are a medication, product or device which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under the Plan, this definition includes insulin and the following diabetic supplies: insulin syringes with needles; blood testing strips – glucose; urine testing strips – glucose; ketone testing strips and tablets; lancets and lancet devices.]

["Psychologist" means an individual who is duly licensed or certified as a Psychologist in those jurisdictions where statutory or nonstatutory licensure or certification exists or, in those jurisdictions where neither exists, an individual who is duly qualified as a professional Psychologist by a recognized psychological association.]

["Reasonable and Customary Charge" means the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed.]

["Registered Graduate Nurse" means a professional nurse who has the right to use the title "Registered Nurse" and the abbreviation "R.N."]

DEFINITIONS (Continued)

["Room and Board"] includes all charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.]

["Serious Injury" or "Serious Sickness"] mean Injury or Sickness certified as being dangerous to life by a legally qualified medical practitioner]

"Serious Mental Illness" is defined as schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorder; panic disorder; anorexia nervosa; bulimia nervosa; schizoaffective disorder and delusional disorder.

["Sickness"] means any physical Sickness, Mental Illness, Substance Abuse or functional nervous disorder diagnosed by a Physician. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. [The term "Sickness" also includes Pregnancy.]]

["Skilled Nursing Facility"] means a lawfully operating institution engaged mainly in providing treatment for people convalescing from Injury or Sickness. It must have:

1. organized facilities for medical services; and
2. 24 hour nursing service by RNs; and
3. a capacity of six or more beds; and
4. daily medical records for each patient; and
5. a Physician available at all times.

If a Skilled Nursing Facility does not have semi-private rooms, "semi-private room rate" means 80% of that facility's daily charge for its lowest rate private room.

Skilled Nursing Facility does not include: rest homes, homes for the aged, and places for Custodial Care or detoxification facilities.]

["Spinal Manipulation"] is a form of manual therapy where an application of forces to structures such as muscles, joints and bones is presented, where the goal is the restoration of normal joint motion and the elimination of pain secondary to disturbed biomechanics.]

["Spouse"] means the Insured Employee's lawful spouse (not including a spouse who is legally separated from the Insured). [The term Spouse will include a Domestic Partner.]]

["Substance Abuse"] means the overindulgence in and dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health, or the welfare of others.]

["Temporomandibular Joint Dysfunction"] is a condition of facial pain in the joints of the lower jaw and is also known as myofascial pain dysfunction syndrome or TMJ.]

"Third Country National" means an Employee who works outside his country of permanent residence and outside the [Policyholder] [Participating Employer]'s country of domicile.

DEFINITIONS
(Continued)

["Total Disability" or "Totally Disabled" an Employee will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is completely unable to perform the duties of his or her regular occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit.

[A Dependent will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is unable to engage in the normal activities of a person of the same age and sex.]]

["Transportation" means moving the Insured Person during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.]

"Waiting Period", shown in the Schedule of Benefits, means the continuous length of time an Employee must serve in an eligible class to reach his eligibility date.

ELIGIBILITY FOR INSURANCE

EMPLOYEES

Each Employee in a class of Eligible Employees will become eligible for insurance on the date he or she completes the Waiting Period, if any. Any Waiting Period will be waived for an Employee previously insured under the Policy, whose insurance terminated for a reason other than cancellation of his or her payroll deduction order, if the Employee becomes employed in one of the classes of Eligible Employees within one year after his or her insurance terminates. The classes of Eligible Employees and the Waiting Period are shown in the Schedule of Benefits.

[DEPENDENTS

Each Eligible Employee will be eligible [for Vision Benefits, Dental Benefits and Medical Insurance] with respect to his or her Dependents on the latest of:

1. the effective date of the Policy; or
2. the date upon which he or she acquires a Dependent; or
3. the effective date of the Employee's insurance under the Policy.]

EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]

EMPLOYEES

[Non-Contributory [- All Coverage's]

If the [Participating Employer's] [Policyholder's] plan under the Policy or any coverage afforded there under is issued on a non-contributory basis, an Eligible Employee's coverage will become effective on the later of:

1. the effective date of the Policy; or
2. the date such Employee becomes eligible.

[With respect to coverage's other than Medical Insurance,] if the Employee is not in Active Service on the date insurance would normally become effective; the effective date of his or her insurance will be the date he or she returns to Active Service.]

[Contributory [- Coverage's other than Medical Insurance]

If the [Participating Employer's] [Policyholder's] plan under the Policy or any coverage [other than Medical Insurance] afforded there under is issued on a contributory basis, each Employee may elect such insurance by signing an enrollment form approved by the [Participating Employer] [Policyholder] and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the [Participating Employer] [Policyholder] on or before that date; or
2. the date on which the enrollment form is received by the [Participating Employer] [Policyholder], if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the [Participating Employer] [Policyholder] more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

**EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]
(continued)**

EMPLOYEES (continued)

[Contributory - Medical Insurance

If the [Participating Employer's] [Policyholder's] plan under the Policy or the Medical Insurance afforded there under is issued on a contributory basis, each Employee may elect such insurance by enrolling on a form approved by the [Participating Employer] [Policyholder] and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the [Participating Employer] [Policyholder] on or before that date; or
2. the date on which the enrollment form is received by the [Participating Employer] [Policyholder], if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which the enrollment form is received by the [Participating Employer] [Policyholder], if that date is within a 30-day Special Enrollment Period; or
4. the date for which the first premium for the Employee's coverage is paid.

If the Employee fails to enroll for contributory Medical Insurance as set forth in 1., 2. or 3. above, such Employee may again enroll for coverage during the 30-day period following the one year anniversary of the date on which he or she was originally eligible or, if later, during the 30-day period following the one year anniversary of the beginning of a Special Enrollment Period.]

[Open Enrollment. The Open Enrollment Period, shown in the Schedule, is a period of time agreed upon by the [Policyholder] [Participating Employer] and the Insurance Company, during which: (a) members of an Eligible Class may apply for insurance; and (b) Insureds may elect to make changes in their amount of insurance or apply for additional insurance. Any changes made during the Open Enrollment Period will take effect on the date shown in the Schedule. Any changes in the amount of insurance during the Open Enrollment will be limited to [one incremental increase]. All other increases will be subject to Evidence of Insurability]

[Annual Enrollment. The Annual Enrollment Period, shown in the Schedule, is a period of time during which any Eligible Insured's may apply for insurance or elect to make changes in their amount of insurance. Any changes in the amount of insurance during an Annual Enrollment will be limited to [one incremental increase]. Any increase either over the Guarantee Issue or more than the limited change amount will be subject Evidence of Insurability.]

[DEPENDENTS

[Non-Contributory [- All Coverage's]

An Insured Dependent's coverage under the Policy will become effective on the later of:

1. the date the Insured Employee becomes eligible for Dependent insurance; or
2. the Insured Employee's effective date of coverage under the Policy.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

[With respect to coverage's other than Medical Insurance,] if a Dependent is Confined in a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.]

**EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]
(continued)**

DEPENDENTS (continued)

[Contributory [- Coverage's other than Medical Insurance]

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] on or before the date he or she becomes eligible; or
2. the date the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder], if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. on the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is Confined in a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.]

[Contributory - Medical Insurance

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] on or before the date he or she becomes eligible; or
2. the date the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder], if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. on the date the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder], if that date is within a 30 day Special Enrollment Period. Coverage for certain Dependents will be effective earlier. See the following "Special Enrollment Periods" section for details; or
4. the date for which the first premium for the Dependent's coverage is paid.]

[If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.]

**EFFECTIVE DATE OF INSURANCE [- U.S. CITIZENS ONLY]
(continued)**

[Special Enrollment Periods

A Special Enrollment Period is a 30-day period during which an Eligible Employee who has previously declined to enroll under the Policy may enroll himself or herself or his or her Dependents. A Special Enrollment Period will be granted under the following conditions:

1. Loss of Other Coverage
 - a. the Eligible Employee or Dependent was covered under another group benefit plan or had health insurance coverage at the time coverage under the Policy was offered; and
 - b. the Eligible Employee declined coverage under the Policy, in writing, on the basis of the other coverage; and
 - c. the Eligible Employee or Dependent lost the other coverage as a result of legal separation, divorce, death, termination of employment or a reduction in the number of hours of employment or Employer contributions toward such coverage were terminated, or
 - d. the Eligible Employee's or Dependent's COBRA coverage is exhausted.

If the Eligible Employee or Dependent lost the other coverage as a result of his or her failure to pay premiums or for cause (including but not limited to making a fraudulent claim), that Eligible Employee or Dependent will not have a Special Enrollment Period.

2. Other

Dependents are entitled to a special 30 day enrollment period if they become Dependents through marriage, birth, adoption or placement for adoption. The effective date of coverage for such a Dependent will be retroactive to the date of marriage, birth, adoption or placement for adoption.]

[EFFECTIVE DATE OF INSURANCE [- NON- U.S. CITIZENS]

EMPLOYEES

[Non-Contributory [- All Coverage's]

If the [Participating Employer's] [Policyholder's] plan under the Policy or the coverage afforded there under is issued on a non-contributory basis, an Eligible Employee's coverage will become effective on the later of:

1. the effective date of the Policy; or
2. the date such Employee becomes eligible for coverage under the Policy.

[If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

[Contributory [- All Coverage's]

If the [Participating Employer's] [Policyholder's] plan under the Policy or any coverage afforded there under is issued on a contributory basis, each Employee may elect for such insurance by signing an enrollment form approved by the [Participating Employer] [Policyholder] and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the [Participating Employer] [Policyholder] on or before that date; or
2. the date on which the enrollment form is received by the [Participating Employer] [Policyholder], if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or

[EFFECTIVE DATE OF INSURANCE [- NON- U.S. CITIZENS]

3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the [Participating Employer] [Policyholder] more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.
If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service.]]

[DEPENDENTS

[Non-Contributory [- All Coverage's]

An Insured Dependent's coverage under the Policy will become effective on the later of:

1. the date the Insured Employee becomes eligible for Dependent insurance; or
2. the Insured Employee's effective date of coverage under the Policy.]

[Contributory [- All Coverage's]

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] on or before the date he or she become eligible for coverage under the Policy; or
2. the date the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder], if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the [Participating Employer] [Policyholder] more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is confined to a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.]]

TERMINATION OF INSURANCE

EMPLOYEES

An Insured Employee's coverage under the Policy will automatically terminate on the earliest of:

1. the date the Employee ceases to be in a class of Eligible Employees or ceases to qualify as an Employee;
2. the date the Employee's Employer ceases to be a [Participating Employer] [Policyholder] under the Policy;
3. the date the Policy is discontinued;
4. the last day for which any required contribution has been made;
5. [90 days] after the date the Employee returns to the U.S to establish residency;
6. the date the Employee ceases to be in Active Service, except as provided below:

Temporary Layoff or Leave of Absence. If an Employee's Active Service terminates because of temporary layoff or leave of absence, the insurance will be continued until the [Participating Employer] [Policyholder] ceases to pay premiums for the Employee or otherwise cancels the insurance. But in no event will the insurance be continued for more than [60 days] following termination of Active Service.

Any continuation of insurance must be in accordance with a plan which precludes individual selection.

[DEPENDENTS

An Insured Dependent's coverage under the Policy will automatically terminate upon the earliest of the following:

1. the date the Insured Employee's coverage under the Policy ends; or
2. the last day for which any required contribution has been made;
- [3. [90 days] after the date the Dependent returns to the U.S to establish residency;]
4. the date the person ceases to qualify as a Dependent.]

[CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

[This Provision Only Applies to U.S. Citizens who remain outside the U.S. following termination of employment.]

This provision describes an Insured Person's rights under COBRA to continue the medical coverage which would otherwise terminate under the Policy.

Coverage for an Insured Person will be continued for the applicable Continuation Period described below if insurance under the Policy is terminated due to one of the Qualifying Events described below. The continued coverage will be at the Insured Person's expense and will be identical to the coverage provided under the Policy at the time of the Qualifying Event. If more than one Qualifying Event occurs, coverage may be extended only for the longest Continuation Period for which the Insured Person is eligible under the terms of this provision.

Continuation Periods and Qualifying Events

18-Month Continuation Period

For any Insured Person, coverage may be continued for up to 18 months if coverage would otherwise terminate under the Policy due to one of the following Qualifying Events:

1. voluntary or involuntary termination of employment, other than for gross misconduct; or
2. reduction in work hours.

11-Month Extension for Disability

The 18-month Continuation Period described above may be extended for an additional 11 months if at the time of the Qualifying Event described above (or at any time during the first 60 days of continued coverage), the Insured

**CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS
BUDGET RECONCILIATION ACT (COBRA)
(continued)**

Person is determined to be disabled by the Social Security Administration. This 11-month extension applies to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment.

36-Month Continuation Period for Dependents Only

Coverage for an Insured Dependent may be continued for up to 36 months, if coverage would otherwise terminate due to the following Qualifying Events:

1. the Employee's death;
2. the divorce or legal separation of the Employee and his or her Insured Dependent Spouse;
3. the Employee's child no longer meets the Policy's definition of Dependent.
4. the Employee becomes entitled to Medicare.

If the Employee does not lose coverage due to Medicare entitlement but later loses coverage due to another Qualifying Event (such as voluntary or involuntary termination or reduction in work hours), coverage for Insured Dependents in such cases may be continued for up to 36 months from the date the Employee first became entitled to Medicare.

A child who is born to or placed for adoption with the Insured Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the COBRA administrator of the birth or adoption.

Election Period

For COBRA continuation of coverage to become effective, an Insured Person eligible for the continuation described above must elect the continuation in writing within 60 days of the later of:

1. the date the Insured Person would otherwise lose coverage due to the Qualifying Event; or
2. the date the Insured Person is notified of the right to elect the continuation of coverage.

The election must be in writing on a form provided by the COBRA administrator designated by the [Participating Employer] [Policyholder]. The form must be completed and returned within the 60-day period indicated above.

If the Qualifying Event is divorce, legal separation, or a child who no longer qualifies as a Dependent under the Policy, the Insured Person must provide notification within 60 days of the date he or she would lose coverage.

If the Insured Person is disabled and qualifies for continued coverage under the 11-month Extension for Disability described above, the Insured Person must notify the COBRA administrator within 60 days of the final determination by the Social Security Administration that he or she is disabled.

Payment of Premium

The Insured Person who has elected to continue coverage shall be solely responsible for the payment of premium for the continued coverage. If election of COBRA continuation is made after the date of the Qualifying Event, premium payment for the continuation of coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments.

**CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS
BUDGET RECONCILIATION ACT (COBRA)
(continued)**

Termination of COBRA Continuation

The continued coverage will cease on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium is due and unpaid after any applicable Grace Period;
3. the date the Insured Person becomes covered under another group health insurance plan. This may not apply if the Insured Person has a Pre-existing Condition which was covered under the Policy but is not covered under the new plan. However, for plan years beginning after July 1, 1997, if the new plan's Pre-existing Condition exclusion would not apply because your Creditable Coverage under the Policy satisfies the new plan's requirements, then coverage under the Policy pursuant to COBRA may be terminated;
4. the date the Insured Person becomes eligible under Medicare;
5. the date the applicable period of continuation is exhausted, or the Lifetime Maximum Benefit under the Policy, if applicable, is paid on behalf of the Insured Person;
6. the date the Insured Person returns and sets up residency in the U.S. for more than [90 continuous days];
7. the first day of the month which begins 30 days after the date the Insured Person receives a final determination from the Social Security Administration that he or she is no longer disabled if continued for the 11-month Extension for Disability described above.]

[THREE MONTH CONTINUATION OF HEALTH INSURANCE COVERAGE]

[This Provision Only Applies to Non-United States Citizens who remain outside the U.S. following termination of employment.]

This provision describes an Insured Person's rights to continue the medical coverage which would otherwise terminate under the Policy.

Subject to continued premium payment by the [Participating Employer] [Policyholder], coverage for an Insured Person will be continued for a period of three months if insurance under the Policy is terminated due to one of the Qualifying Events described below. The continued coverage will be identical to the coverage provided under the Policy at the time of the Qualifying Event.

Qualifying Events

For any Insured Person, coverage may be continued if coverage would otherwise terminate under the Policy due to one of the following Qualifying Events:

1. voluntary or involuntary termination of employment, other than for gross misconduct; or
2. reduction in work hours.

Coverage for an Insured Dependent may be continued if coverage would otherwise terminate due to the following Qualifying Events:

1. the Employee's death;
2. the divorce or legal separation of the Employee and his or her Insured Dependent Spouse;
3. the Employee's child no longer meets the Policy's definition of Dependent.
4. the Employee becomes entitled to Medicare.

A child who is born to or placed for adoption with the Insured Employee during a period of continued coverage will be eligible to become a qualified beneficiary. These qualified beneficiaries can be added to continued coverage upon proper notification to the plan administrator of the birth or adoption.

Election Period

For continuation of coverage to become effective, an Insured Person eligible for the continuation described above must elect the continuation in writing within 31 days of the later of:

1. the date the Insured Person would otherwise lose coverage due to the Qualifying Event; or
2. the date the Insured Person is notified of the right to elect the continuation of coverage.

The election must be in writing on a form provided by the [Participating Employer] [Policyholder]. The form must be completed and returned within the 31-day period indicated above.

If the Qualifying Event is divorce, legal separation, or a child who no longer qualifies as a Dependent under the Policy, the Insured Person must provide notification within 31 days of the date he or she would lose coverage.

Termination of Continued Coverage

The continued coverage will cease on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium is due and unpaid after any applicable Grace Period;
3. the date the Insured Person becomes covered under another group health insurance plan.
4. the date the Insured Person becomes eligible under Medicare;
5. the date the Insured Person returns and sets up residency in the U.S. for more than [90 continuous days];
6. the date the three month period of continuation is exhausted, or the Lifetime Maximum Benefit under the Policy, if applicable, is paid on behalf of the Insured Person.]

[MEDICAL BENEFITS

Medical Benefits are payable for expenses incurred by each person while insured under the Policy. Such expenses must be for medical treatment that results from Injury or Sickness. Such expenses must also be Medically Necessary and prescribed or ordered by a Physician.

Medical Benefits are determined this way:

1. Subtract any Medical Deductible from Covered Medical Expenses incurred; and
2. Multiply the result by the Percentage Payable that applies to the Covered Medical Expenses.

Medical Benefits payable will not exceed any of the applicable maximum benefits.

Deductibles, Percentage Payable and maximum benefits are shown in the Schedule of Benefits.

Medical Deductible(s)

Individual Medical Deductible

The Individual Medical Deductible, shown in the Schedule of Benefits, applies to each Insured Person once each [calendar] year. It is a dollar amount of Covered Medical Expenses for which no benefits are payable.

[Family Medical Deductible

If, in any [calendar] year, Covered Medical Expenses used toward the Individual Medical Deductibles of an Insured Employee and his Insured Dependents equals the Family Medical Deductible shown in the Schedule of Benefits, the Individual Deductible will be deemed to be met with respect to Covered Medical Expenses incurred by such Insured Employee and his Insured Dependents for the rest of that [calendar] year.]

[CREDIT FOR MEDICAL DEDUCTIBLE(S). Covered Medical Expenses which were applied toward the Medical Deductible(s) during the last three months of a [calendar] year will be applied to the Medical Deductible(s) of the next [calendar] year.]

[COMMON ACCIDENT. If an Insured Employee and one or more of his or her Insured Dependents or if two or more of an Insured Employee's Insured Dependents sustain Injuries in the same accident and, as a result of those Injuries, incur Covered Medical Expenses during the same [calendar] year in which the accident occurs, only one Medical Deductible will be deducted from the total Covered Medical Expenses incurred for those individuals during the remainder of that [calendar] year.]

Out-of-Pocket Maximum - [Does not apply to charges for Treatment of Mental Illness and/or Substance Abuse [or to charges for Air Ambulance service].] The Deductible is [NOT] included in the Out-of-Pocket Maximum.]

Individual Out-of-Pocket Maximum

If out-of-pocket expense used to meet the percentage of Covered Medical Expenses that an Insured Employee pays due to the Percentage Payable provision exceeds the Individual Out-of-Pocket Maximum for himself or one of his or her Insured Dependents, Medical Benefits for that one Insured Person will be payable at 100% of such Covered Medical Expense. The Individual Out-of-Pocket Maximum applies on a [calendar] year basis. It is shown in the Schedule of Benefits.

[Family Out-of-Pocket Maximum

If out-of-pocket expense used to meet the percentage of Covered Medical Expenses that an Insured Employee pays due to the Percentage Payable provision exceeds the Family Out-of-Pocket Maximum for all Insured Persons in a family in any [calendar] year, Medical Benefits will be payable at 100% of Covered Medical Expense for the rest of that [calendar] year. The Family Out-of-Pocket Maximum is shown in the Schedule of Benefits.]

MEDICAL BENEFITS (Continued)

Percentage Payable

Medical Benefits are paid at percentages of Covered Medical Expenses incurred. These percentages are called the "Percentage Payable". Where the Percentage Payable is less than 100%, the Insured Person is responsible for the difference. The Percentage Payable is shown in the Schedule of Benefits.

Maximum Benefits

Lifetime Maximum Benefit

The Lifetime Maximum Benefit, shown in the Schedule of Benefits, applies to each Insured Person. It is the total of benefits payable for Covered Medical Expenses.

Reinstatement of Lifetime Maximum Benefit

Benefits paid are deducted from the Lifetime Maximum Benefit. Benefits are automatically reinstated [each year on January 1][on the beginning of the plan year]. The amount reinstated is the lesser of:

1. [\$1,000]; or
2. the amount paid for all charges incurred in the prior [calendar] [plan] year.

This is added to the unused amount of the Lifetime Maximum Benefit.

Other Maximums

In addition to the Lifetime Maximum Benefit, certain Covered Medical Expenses are also subject to other internal limits or maximums. These additional maximums are shown in the Schedule of Benefits.

[Pre Certification for [U.S.] [or Canadian] Hospital Confinements [and any Air Ambulance Service]

Pre certification is a program in which the Insurance Company reviews all inpatient Hospital treatment in the [U.S.] [or Canada] [and any request for air ambulance service for medical necessity].

Under this program, all [U.S.] [or Canadian] inpatient Hospital Confinements [and all requests for air ambulance service] must be certified by the Insurance Company. Procedures for requesting certification are outlined below. ***If an Insured Person fails to follow these procedures, benefits payable for Covered Medical Expenses for charges incurred in connection with the Hospital Confinement [or air ambulance service] will be reduced to 50% of what would otherwise be payable.*** Expenses for charges incurred that are not payable because of this penalty are not Covered Medical Expenses and won't count toward the Out-of-Pocket Maximums.

Non-Emergency Hospitalization [or Air Ambulance Service]

All non-emergency inpatient Hospital admissions [in the U.S.] [or Canada] [and requests for air ambulance service anywhere] must be certified in advance by the Insurance Company. An Insured Person or his or her attending Physician must call the Insurance Company for certification at least five calendar days before a non-emergency [U.S.] [or Canadian] inpatient Hospital admission [or scheduled air ambulance service]. If the Insurance Company determines that the admission or service is Medically Necessary, the Insured Person will be notified that the Hospital admission [or air ambulance service] has been certified. If the admission [or service] is not authorized, the Insured Person will be advised of this determination. If the Insured Person does not receive notification prior to the scheduled admission or service date, he or she should contact the Insurance Company to determine the recommendation that it has taken with respect to that Hospital admission [or request for air ambulance service].

MEDICAL BENEFITS (Continued)

Pre-Admission Certification (continued)

Emergency Hospitalization [or Air Ambulance Service]

In an emergency Hospital admission [or emergency air ambulance service], a request to certify must be made within 48 hours or on the next business day following the Insured Person's admission [or air ambulance service]. "Emergency admission [or air ambulance service]" means an inpatient Hospital admission [or air ambulance service] for an Emergency Medical Condition.

Important Note

If an Insured Person proceeds with a [U.S.] [or Canadian] inpatient Hospital [or an air ambulance service] which has been determined as not Medically Necessary, and if a post claim review confirms this determination; no benefits are payable for any charges incurred in connection with that confinement [or service].]

Covered Medical Expenses

The term Covered Medical Expenses means expenses incurred by or on behalf of an Insured Person for the charges listed below but only if: (a) the expenses are Medically Necessary; and (b) the treatment giving rise to the expenses is prescribed or ordered by an attending Physician. Covered Medical Expense will not include amounts in excess of the Reasonable and Customary Charge. Covered Medical Expenses will be subject to any applicable limitations or maximums shown in the Schedule of Benefits.

The date the service is performed or the supply is purchased is the date Covered Medical Expense is incurred.

1. charges made by a Hospital, on its own behalf, for Room and Board and other Miscellaneous Services and Supplies and for medical care and treatment provided on an outpatient basis;
2. charges made by a facility licensed to furnish treatment of Mental Illness or Substance Abuse, on its own behalf for care and treatment provided on an inpatient basis;
3. charges made by a facility licensed to furnish treatment of Mental Illness or Substance Abuse, on its own behalf for care and treatment provided on an outpatient basis;
4. charges made by a Free-Standing Surgical Facility for services in connection with outpatient surgery, and which are incurred on the day of the surgery or within 48 hours after the surgery;
5. charges for Scalp Hair Prosthesis for hair loss suffered as a result of alopecia areata;
6. charges for an individual hearing aid , per ear, every 3 years, for children less than 24 years of age, covered as a dependent
6. charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment;

MEDICAL BENEFITS
(Continued)

Covered Medical Expenses (continued)

7. charges made by a Home Health Care Agency for treatment rendered in an Insured Person's home pursuant to a Home Health Care plan. Covered Medical Expenses for Home Health Care are limited to the following:
- (a) part-time or intermittent nursing care by or under the supervision of an RN, LPN or LVN;
 - (b) part-time Home Health Aide services that consist primarily of caring for the patient;
 - (c) services provided by a licensed or certified midwife or nurse midwife;
 - (d) medical social services by licensed or trained social workers, Psychologists or counselors;
 - (e) services by licensed physical, occupational or speech therapists;
 - (f) nutrition services provided by a licensed dietitian;
 - (g) medical supplies attendant to the above services to the extent they are covered under the Policy;

Provided further, that in determining the limit of benefits for services in (a) through (e) above:

- (i) each visit by a member of a home health care team (other than a Home Health Aide) will be counted as one home health care visit; and
 - (ii) four hours or less of Home Health Aide service will be counted as one home health care visit;
8. charges for a Physician's professional services including those of a licensed midwife. Charges made by an assistant surgeon or surgical assistant are Covered Medical Expense when such assistance is: (a) Medically Necessary; (b) such person actively participates in the surgery; and (c) such person is not an Employee of the facility where surgery is performed. Charges made by an assistant surgeon or surgical assistant in excess of 20% of the Reasonable and Customary surgeon's charge for the surgery are not covered;
9. charges made by a Registered Graduate Nurse for professional outpatient nursing services;
10. charges made for anesthesia and its administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental of an oxygen breather; diabetic supplies or other Durable Medical Equipment; physical therapy; prosthetic appliances; dressings; and drugs and medicines lawfully obtainable only upon the written prescription of a Physician;
11. Charges made by a Hospice for Hospice Care Expense incurred by a terminally ill Insured Person during a Hospice Benefit Period;
12. charges for professional ambulance service in connection with an Emergency Medical Condition. Covered Medical Expenses for the service are limited to charges for land Transportation to the nearest Hospital equipped to render treatment for the condition. [Air Transportation is covered only when Medically Necessary.]
13. [Oral Contraceptive Drugs or devices used to prevent Pregnancy.]
14. [Treatment of Infertility subject to any maximums indicated on the Schedule of Benefits. [However, services for In Vitro Fertilization are limited to [four] eggs per lifetime, are not subject to the Schedule of Benefit maximums, and the following criteria must be met before these services are covered:
- The patient's eggs must be fertilized with her Spouse's sperm;
 - The patient is unable to get pregnant through less expensive covered treatments;
 - The In Vitro Fertilization must be performed at facilities that conform to standards set by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.
 - The patient and his or her Spouse must have at least a [five-year] history of Infertility; or their Infertility must be associated with one or more of the following conditions;
 - * Endometriosis;
 - * Fetal exposure to diethylstilbestrol, also known as DES; or
 - * Blocked or surgically removed fallopian tubes.]]

**MEDICAL BENEFITS
(Continued)**

[Adult Preventive Care Benefits

Benefits are payable for charges incurred by a Insured Person for certain health examinations that are not due to an Injury or Sickness, subject to any limitations or maximums shown in the Schedule of Benefits. Charges for examinations that diagnose Injury or Sickness will be considered as due to and part of the treatment of the diagnosed condition and will not be considered Covered Medical Expenses under this provision.

Covered Expenses:

The following will be considered Covered Medical Expense under this provision:

1. charges for routine general physical examinations not to exceed:
 - one examination per two year period for persons age 18 through age 64;
 - one examination per year for persons age 65 or older;
- [2. charges for Papanicolaou's (Pap) tests; not to exceed one per year;
3. charges for electrocardiograms (EKG);
4. charges for X-ray examinations and laboratory tests;
- [5. charges for routine mammography screening as follows:
 - for women age 35 through age 39, one baseline mammogram;
 - for women age 40 through age 49, one baseline mammogram every one or two year period, based upon recommendation of a Physician
 - for women age 50 or older, one mammogram per year;
 - for women based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population, one mammographic examination;]
- [6. charges for routine ear examination when performed by an audiologist or otolaryngologist, not to exceed [one in any two year period;]]
- [7. charges for routine eye examination when performed by an optometrist or ophthalmologist, not to exceed [one in any two year period;]]
- [8. charges for prostate cancer screening (PSA) test for men being age 50 or older;]
- [9. charges for CA-125 monitoring of ovarian cancer subsequent to treatment;]
- [10. charges for immunizations including travel immunizations;]
- [11. for persons age 50 or older, screening with annual fecal occult blood tests (3 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable screening tests available.]

Exceptions:

[Additional Benefits (Not Subject to [\$400.00] Calendar Year Maximum):

The following will be considered Additional Benefits under this provision:

- [1. charges for Papanicolaou's (Pap) tests, not to exceed one per year;]
- [2. charges for routine mammography screening as follows:
 - For women age 35 through 39, one baseline mammogram;
 - For women age 40 through 49, one baseline mammogram every two year period based upon recommendation of a physician
 - For women age 50 or older, one mammogram per year;
 - For women based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population, one mammographic examination;]
- [3. charges for immunizations including travel immunizations;]
- [4. charges for prostate cancer screening (PSA) test for men being age 40 or older;]
- [5. charges for CA-125 monitoring or ovarian cancer subsequent to treatment;]
- [6. for persons age 50 or older, screening with annual fecal occult blood tests (3 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable screening tests available.]]

The following are not considered Covered Medical Expenses under this provision:

1. charges for tests or examinations that diagnose Injury or Sickness;
2. charges for tests or examinations given while the Insured Person is Confined in a Hospital or other medical facility.]

MEDICAL BENEFITS (Continued)

[Coverage for Routine Newborn Care

Benefits are payable for routine charges incurred by an Insured Employee's newborn child as follows, subject to any limitations or maximums shown in the Schedule of Benefits:

1. Hospital charges for routine nursery care during the mother's confinement, not to exceed [four] days;
2. Physician's charges for circumcision;
3. Physician's charges for visits to the newborn child in the Hospital;
4. Benefits for hearing loss screening tests provided by a Hospital before discharge.]

[Well Baby/Child Care

Charges incurred for routine preventive care and immunizations of an Insured Dependent Child who is under eighteen years of age will be considered Covered Medical Expense under the Policy even though such charges are not the result of an Injury or Sickness.

Charges for a baseline lead poisoning screening test for children at or around 12 months of age along with lead poisoning screening and diagnostic evaluations for children under the age of six years who are at high risk for lead poisoning.

Benefits are subject to any limitations or maximums shown in the Schedule of Benefits.]

[EMERGENCY MEDICAL EVACUATION BENEFITS

If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside of his or her country of citizenship, the Insurance Company will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to [\$250,000] for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. An Emergency Evacuation must be ordered by the Insurance Company or a Physician who certifies that the severity or the nature of such person's Injury or Sickness warrants such person's Evacuation.

Covered expenses are those for Transportation and medical treatment, including medical services and medical supplies necessarily incurred in connection with an Insured Person's Emergency Evacuation. All Transportation arrangements made for evacuating such person must be by the most direct and economical route possible. Expenses for Transportation must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting such person; and (c) arranged and authorized in advance by the Insurance Company.

[Repatriation of Remains

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside his or her country of citizenship, the Insurance Company will pay for covered expenses reasonably incurred to return his or her body to his or her country of citizenship, up to [\$25,000].]

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for Transportation of the remains; and (3) Transportation of the remains by the most direct and economical conveyance and route possible.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.]

**MEDICAL BENEFITS
(Continued)**

[Emergency Family Travel]

If an Insured Person is hospitalized for more than 5 days, the Insurance Company will pay up to **[\$10,000]** for the cost of round-trip economy airfare to bring a person chosen by the Insured Person to and from such Insured Person's bedside if such person is alone.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.]]

[Return of Dependents]

If an Insured Person is hospitalized for more than 3 days, the Insurance Company will pay up to **[\$10,000]** for the cost of economy airfare for Transportation of the Insured Dependent to his or her country of citizenship or otherwise designated location. This will include an escort to accompany an otherwise unaccompanied minor Dependent Child during the journey.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.]]

Exclusions and Limitations

In addition to the provisions of the Policy titled "Medical Exclusions" and "General Limitations, the following will apply solely to the benefits afforded under the Emergency Medical Evacuation Benefits:

No benefits are payable for:

- [Claims arising from depression or anxiety, mental or nervous disorder, alcohol or drug abuse addiction or overdose;]
- [Claims arising from elective cosmetic or plastic surgery, except as a result of an accident;]
- [Claims arising from Pregnancy and all related conditions;]
- [a Pre-existing Condition as defined in the Policy;]
- [an Insured Person traveling against the advice of a Physician;]
- [Claims directly caused by or directly resulting from:
 - a. any business or financial contractual obligations of the Insured Person or Insured Person's Immediate Family Member;
 - b. Change of plans or disinclination of the Insured Person or Insured Person's Immediate Family Member to travel.]]

**MEDICAL BENEFITS
(Continued)**

[PRESCRIPTION DRUG BENEFITS

Benefits are payable for outpatient Prescription Drugs obtained in the U.S. only. Prescription Drugs obtained outside the U.S. are covered under the Medical Benefits. The Prescription Drugs must be prescribed for:

- Medically Necessary treatment of an Accidental Injury, Sickness or Pregnancy.
- [Prevention of Pregnancy.]

[If the Prescription Drug is a Brand Name Drug, the Co-payment is lower for the preferred version of a dual-marketed drug. Brand Name Drugs, which are not on the Preferred Drug List, are subject to a higher Co-payment.]

[Certain Prescription Drugs require Prior Authorization by a Pharmacists or Physician from the Insurance Company or its designee.]

The Insured Person must be covered under this Prescription Drug Benefit when the prescription is filled.

Network Pharmacy

When a Network Pharmacy is used, the Insured Person pays the Co-payment. Co-payment amounts are shown above.

If the Prescription Drug Cost is less than the Co-payment, the Co-payment does not apply and the Insured Person pays the Prescription Drug Cost.

Network Pharmacies dispense Generic Drugs whenever possible.

For Generic Drugs, an Insured Person pays the Generic Drug Co-payment.

[An Insured Person pays the Brand Name Drug Co-payment for Brand Name Drugs dispensed under either of the following conditions:

- There is no equivalent Generic Drug for substitution.
- The Physician orders a Brand Name Drug. This is usually done by writing "Dispense as written" on the prescription.]

[For Brand Name Drugs which do not have a Generic Drug equivalent, an Insured Person pays the Brand Name Drug Co-payment.]

[For all other Brand Name Drugs, an Insured Person pays:

- The Generic Drug Co-payment
- The difference in cost between the Generic Drug and the Brand Name Drug dispensed. The difference is not counted as a Covered Expense under **Medical Benefits.**]

Non-Network Pharmacy

[There is no coverage for Prescription Drugs dispensed at a Non-Network Pharmacy.]

[When a Non-Network Pharmacy is used, the Insured Person must pay for the entire cost of each prescription at the time it is filled. Then the Insured Person must submit a claim. Benefits are payable at the predominant contracted reimbursement rate (including any sales tax) for Network Pharmacies minus the applicable Co-payment.]

[When a Non-Network Pharmacy is used, the Insured Person must pay for the entire cost of each prescription at the time it is filled. Then the Insured Person must submit a claim. Benefits are payable [at the Non-Network level] under Medical Benefits.]

**MEDICAL BENEFITS
(Continued)**

**PRESCRIPTION DRUG BENEFITS
(Continued)**

[Mail Service Network Pharmacy

A mail service pharmacy option has been provided for convenience. If the mail service is used, the Insured Person must pay the Co-payment.

There is no covered for Prescription Drugs dispensed by a Non-Network Mail Service Pharmacy.

Mail service pharmacies dispense Generic Drugs whenever possible.

For Generic Drugs, an Insured Person pays the Mail Service Generic Drug Co-payment.】

[An Insured Person pays the Mail Service Brand Name Drug Co-payment for Brand Name Drugs dispensed under either of the following conditions:

- There is no equivalent Generic Drug for substitution.
- The Physician orders a Brand Name Drug. This is usually done by writing “Dispense as written” on the prescription.】

[For Brand Name Drugs which do not have a Generic Drug equivalent, an Insured Person pays the Mail Service Brand Name Drug Co-payment.】

[For all other Brand Name Drugs, an Insured Person must pay:

- The Mail Service Generic Drug Co-payment.
- The difference in cost between the Generic Drug and the Brand Name Drug. The difference is not counted as a Covered Expense under **Medical Benefits.**】

Supply Limits

Retail Pharmacy

If the Prescription Drug is dispensed by a retail Pharmacy, the following limits apply:

- [Up to a [31-day]supply of a Prescription Drug, unless adjusted based on the drug manufacturer’s packaging size. Some products may be subject to additional supply limits adopted by the Insurance Company. A list of current additional supply limits may be obtained from the Insurance Company. Up to [three - six - twelve] cycles can be purchased at one time if a Co-payment is paid for each cycle supplied. [Insurer approval required prior to purchase of a twelve cycle supply.】]
- [A one cycle supply of an oral contraceptive. Up to [three - six - twelve] cycles can be purchased at one time if a Co-payment is paid for each cycle supplied.]

[Mail Service Pharmacy

If the Prescription Drug is dispensed by a mail service pharmacy, the supply limit is up to a 90 day supply of a Prescription Drug, unless adjusted based on the drug manufacturer’s packaging size or any additional supply limits adopted by the Insurance Company. A list of current supply limits may be obtained from the Insurance Company.】

Identification Card

If an Insured Person does not show the identification card at the time Prescription Drugs are obtained, the Insured Person will be required to pay the full cost of the Prescription Drug and get payment from the Insurance Company. In that case, benefits are calculated at the predominant contract reimbursement rate for a Network Pharmacy (including any sales tax), less the applicable Co-payment.

**MEDICAL BENEFITS
(Continued)**

**PRESCRIPTION DRUG BENEFITS
(Continued)**

Exclusions and Limitations

In addition to the provisions of the Policy titled "Medical Exclusions" and "General Limitations, the following will apply to Prescription Drug Benefits:

No Prescription Drug Benefits are payable for:

- [Drugs for Infertility treatment;]
- [Drugs given while Confined in a Hospital, nursing home or similar place that has its own drug dispensary]
- [Therapeutic devices or appliances, including colostomy supplies and support garments, regardless of intended use. (This exclusion does not apply to insulin syringes with needles, blood testing strips - glucose, urine testing strips - glucose, ketone testing strips and tablets, lancets and lancet devices which are covered.)]
- [Injectable drugs (This exclusion does not apply to insulin or self-administered injectables which can be injected subcutaneously which are covered.);]
- [Progesterone suppositories;]
- [Appetite suppressants and other weight loss products;]
- [General and injectable vitamins (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered.);]
- [Drugs dispensed in any amount which exceed the supply limits;]
- [Replacement drugs resulting from a lost, stolen, broken or destroyed Prescription Order or Refill;]
- [Unit dose packaging of drugs;]
- [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug;]
- [Contraceptive drugs or devices, when ordered for contraceptive purposes;]
- [Drugs for tobacco dependency or smoking cessation].
- [Drugs for, or in connection with cosmetic surgery unless the Insured Person is injured as a result of an accident that occurs while he or she is covered for Medical Benefits under the Policy, which results in damage to his or her person requiring the cosmetic surgery;]]

Extension of Medical Benefits.

Covered Medical Expenses incurred after termination of an Insured Person's Medical Benefits will be considered Covered Medical Expenses incurred while that insurance is in force, provided: (a) they are incurred prior to the end of the [three - twelve month] period immediately following the date on which that insurance terminated; and (b) they result either from an Injury or a Sickness which causes the Insured Person to be Totally Disabled continuously from the day his or her insurance terminates until the day the Covered Medical Expenses are incurred.

However, the Extension of Medical Benefits will cease to apply to a person as of the date he or she becomes insured for medical care benefits provided under another group insurance plan or under any other arrangement of coverage for individuals in a group.

MEDICAL BENEFITS
(Continued)

Medical Exclusions

Covered Medical Expenses will not include, and no payment will be made for expenses incurred:

- [1. for services or supplies to the extent that benefits are available for the services or supplies elsewhere under the Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the [Participating Employer] [Policyholder] contributes or makes payroll deductions whether or not an Insured Person is covered for such benefits;]
- [2. for services or supplies for which benefits are not payable because of deductible or co-payment provisions under the Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the [Participating Employer] [Policyholder] contributes or makes payroll deductions;]
- [3. for, or in connection with cosmetic surgery unless the Insured Person is injured as a result of an accident that occurs while he or she is covered for Medical Benefits under the Policy, which results in damage to his or her person requiring the cosmetic surgery;]
- [4. for [eyeglasses], [hearing aids] or examinations for prescription or fitting of [eyeglasses] or [hearing aids] unless specifically provided for elsewhere in the Policy; including any surgical procedures which are done primarily to correct a [refractive error] or [hearing loss].]
5. [for, or in connection with treatment of the teeth or gums unless such expenses are incurred for (a) charges made for or in connection with dental work necessitated by Accidental Injury to natural teeth sustained while the Insured Person is covered for Medical Benefits under the Policy for services provided within [90 days] of the accident, or (b) charges made by a Hospital for Room and Board or Miscellaneous Services and Supplies;]
6. [Charges for Oral Contraceptives Drugs or Devices used primarily to prevent Pregnancy;]
- [7. for which benefits are not payable according to the section of the Policy entitled General Limitations.]

[Pre-existing Condition Limitation [For Late Entrants Only]

A Pre-existing Condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received within [six months] preceding of a person's effective date. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from a Physician.

A Covered Person shall not be entitled to payment for Covered Services performed in connection with a Pre-existing Condition for the first twelve (12) months, this or a prior carrier Contract providing payment for such Covered Services has been in effect without interruption.

With respect to a Pre-existing Condition:

no benefits are payable for a expenses incurred for an elimination period of twelve months beginning with the first day of any required Waiting Period under the Policy. This limitation will not apply to Pregnancy, to a newborn child or to a newly adopted child under age 18. [Any period of Creditable Coverage under a prior plan will be subtracted from the twelve month elimination period. However, if there has been a period of 63 days between the date coverage ended under such prior plan and the first day of any required Waiting Period under the Policy, any period of Creditable Coverage under such prior plan will *not* be subtracted from the twelve month elimination period.]]

[DENTAL BENEFITS

Dental Benefits are payable for Covered Dental Expenses incurred by an Insured Person.

Dental Benefits are determined this way:

1. subtract any Dental Deductible from Covered Dental Expense; and
2. multiply the result by the Percentage Payable.

Dental Deductible(s)

Individual Dental Deductible

The Individual Dental Deductible applies to each Insured Person. It is a dollar amount of Covered Dental Expense that must be met once each calendar year before benefits are payable for Dental Services.

[Family Dental Deductible

If the sum of Covered Dental Expenses used toward an Employee's and his or her Dependents' individual Dental Deductibles in a calendar year equals the Family Dental Deductible, the Individual Dental Deductible will be deemed to be met with respect to Covered Dental Expenses incurred by all Insured Persons in that family for the rest of that calendar year.]

The Individual Dental Deductible [and the Family Dental Deductible] are shown in the Schedule of Benefits.

[CREDIT FOR DENTAL DEDUCTIBLE(S). Covered Dental Expenses which were applied toward the Dental Deductible(s) during the last three months of a calendar year will be applied to the Dental Deductible(s) of the next calendar year.]

Percentage Payable

Dental Benefits are paid at percentages of Covered Dental Expenses incurred. These percentages are called the "Percentage Payable". Where the Percentage Payable is less than 100%, the Insured Person is responsible for the difference. The Percentage Payable is shown in the Schedule of Benefits.

Covered Dental Expenses

Covered Dental Expenses are the Reasonable and Customary Charges for Dental Services. This amount will not exceed the actual charge. Covered Dental Expenses must be incurred while insured. Dental Services means those services listed in Parts I, II or III of the Schedule of Dental Services. Such services must be done by or under the direction of a Dentist and must be: (a) required for the treatment or management of the dental condition; (b) commonly and customarily recognized by Dentists as appropriate in the treatment or management of the dental condition (as determined by the ADA or other recognized dental boards); (c) other than educational or experimental; (d) not primarily for the comfort or convenience of the Dentist or Insured Person; and (e) given in the most cost efficient setting consistent with maintaining high quality care.

Date Incurred

The date Covered Dental Expenses are incurred will be:

1. for full or partial dentures, on the date the final impression is taken;
2. for fixed bridges, crowns, inlays and onlays, on the date the teeth are first prepared;
3. for root canal therapy, on the later of: (a) the date the pulp chamber is opened; or (b) the date the canals are explored to the apex;
4. for periodontal surgery, on the date the surgery is actually performed;
5. for all other services, on the date the service is performed.

**DENTAL BENEFITS
(Continued)**

Calendar Year Maximum Benefit

The Calendar Year Maximum Benefit is the total of benefits payable for Covered Dental Expense incurred by an Insured Person in a calendar year. It is shown in the Schedule of Benefits

Late Entrants

Dental Benefits for an Insured Person who is a Late Entrant will be limited to the following:

- (1) [Only Part I services during the first six months the person is covered; and]
- (2) [Only Part I and Part II services during the second six months the person is covered.]

If an Insured Person who is a Late Entrant suffers a Covered Dental Injury more than 90 days after becoming covered under this plan, benefits will be payable for Covered Dental Expenses incurred as a result of such Injury, as if the person were not a Late Entrant.

Schedule of Dental Services

The following is a list of Dental Services that will be considered for payment.

A temporary Dental Service will be considered a part of the final Dental Service.

**SCHEDULE OF DENTAL SERVICES
PART I - PREVENTIVE**

PROCEDURE

LIMITATIONS

[Oral Examination	Limited to twice in any one year period.
Emergency Oral Examination	
Complete Mouth Survey or Panoramic X-ray	Limited to once in any three year period. Includes bitewings and 10 to 14 periapical X-rays.
Individual Periapical X-rays	
Occlusal X-rays	Limited to once in any one year period
Extraoral X-rays	Limited to once in any one year period
Bitewing X-rays	Limited to twice in any one year period.
Other X-rays	
Bacteriologic Cultures	
Dental Prophylaxis	Limited to twice in any one year period.
Fluoride Treatments	Limited to twice in any one year period. Limited to children under the age of 16.]

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART I - PREVENTIVE
(Continued)**

[Space Maintainers	Limited to children under the age of 16.
Biopsy	
Palliative Treatment	Paid as a separate benefit only if no other service is rendered during the visit, except X-rays.
Application of Sealants	Limited to one application per tooth in any three year period and only for the first and second permanent molars of Insured Dependent Children under 15 years of age.]

**SCHEDULE OF DENTAL SERVICES
PART II - BASIC**

PROCEDURE

LIMITATIONS

[Diagnostic Casts	Limited to once in any three year period.
Amalgam Restorations	Multiple restorations on one surface will be paid as a single filling.
Pin Retention	Covered only in conjunction with an amalgam or composite restoration.
Silicate Restorations	
Plastic Restorations	
Composite Restorations	Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.
Re-Cement Inlays	
Re-Cement Crowns	
Crown Build-up	Covered only for endodontically treated teeth which require crowns.
Pulpotomy	
Root Canal Therapy	
Apicoectomy and Retrograde	Paid as a separate benefit only if Filling performed more than 12 months after the root canal therapy is completed.
Hemisection	
Provisional Splinting]	

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART II - BASIC
(Continued)**

PROCEDURE

LIMITATIONS

[Occlusal Adjustment	Covered only when performed with Periodontal Surgery or TMJ treatment.
Scaling and Root Planing	Limited to two times per quadrant of the mouth in any one year period.
Periodontal Prophylaxis	Limited to a combined maximum of one prophylaxis in any six consecutive month period including prophylaxis and periodontal prophylaxis.
Relining Dentures	Limited to relining done more than 12 months after the initial insertion, and then not more than once in any two year period.
Tissue Conditioning	
Repairs to Full Dentures, Partial Dentures, and Bridges	Limited to repairs or adjustments performed more than 12 months after the initial insertion.
Repairs to Crowns	
Re-Cement Bridges	
Simple Extraction	
Surgical Extraction Including Extraction of Impacted Teeth	
Root Recovery	
Excision of Pericoronal Tissues	
Incision and Drainage	
General Anesthesia	Will be paid as a separate benefit only when required for complex oral surgical procedures, provided such procedures are otherwise covered under the Policy.
Therapeutic Drug Injections]	

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART III - MAJOR**

All benefits for the services listed below include an allowance for all temporary restorations and appliances.

PROCEDURE

LIMITATIONS

[Gold Inlays and Onlays

Covered only when the tooth cannot be restored by a filling, and then only if more than five years has elapsed since the last placement.

Porcelain Restorations

Crowns

Covered only when the tooth cannot be restored by a filling, and then only if more than five years has elapsed since the last placement. For Insured Persons under 16 years of age, benefits are limited to Plastic or Stainless Steel Crowns.

Stainless Steel Crowns

Covered only when the tooth cannot be restored by a filling.

Post and Core

Covered only for endodontically treated teeth requiring crowns.

Gingivectomy *

Gingival Curettage *

Mucogingival Surgery *

Osseous Surgery *

* Only one of these surgical procedures per area of the mouth is covered in any one year period.

Osseous Grafts

Pedicle Grafts

Free Soft Tissue Grafts

Vestibuloplasty

Periodontal Appliance

Limited to one appliance in any one year period.

Full Dentures

There are no additional benefits for overdentures or customized dentures.

Partial Dentures

A partial denture includes clasps, rests and teeth. There are no additional benefits for precision or semi-precision attachments.

Denture Adjustments

Only covered once in any one year period, and only if performed more than 12 months after the insertion of the denture.]

**DENTAL BENEFITS
(Continued)**

**SCHEDULE OF DENTAL SERVICES
PART III - MAJOR
(Continued)**

PROCEDURE

LIMITATIONS

[Fixed Bridges

Maryland Bridge

Tooth Re-Plantation

Tooth Transplantation

Alveoplasty

Stomatoplasty

Removal of Exostosis

Frenectomy (Frenulectomy)

Excision of Hyperplastic Tissue]

DENTAL BENEFITS (Continued)

[Orthodontics Benefits

[Dental Benefits will also include orthodontics for *Insured Dependent Children up to age 19 only.*]

Benefits for orthodontics are determined this way:

1. subtract any Orthodontic Deductible from Covered Orthodontic Expenses; and
2. multiply the result by the Percentage Payable for orthodontics.

Covered Orthodontic Expenses

Covered Orthodontic Expenses means the Reasonable and Customary Charges for the following services. This amount will not exceed the actual charge.

1. Cephalometric x-rays.
2. Tooth movement for periodontal purposes.
3. Surgical exposure of impacted teeth.
4. Orthodontic treatment.

Covered Orthodontic Expenses must be incurred while insured under the Policy. Covered Orthodontic Expenses does not include orthodontic expenses if the appliance or bands are inserted before the person becomes insured under the Policy.

Date Incurred

The date all Covered Orthodontic Expenses are incurred will be:

1. the date the bands are inserted;
2. the date the appliance is inserted;
3. the date a procedure is performed, if it's completed on the same day it was started.

Lifetime Orthodontic Maximum

The total amount payable for Covered Orthodontic Expenses during an Insured Person's lifetime will not exceed the Lifetime Orthodontic Maximum shown in the Schedule of Benefits.

Benefit Payments

An orthodontic treatment plan must be submitted to the Insurance Company before benefits are payable for Covered Orthodontic Expense. Total benefits for the course of treatment will then be determined and divided into monthly benefits as follows:

1. Single Charge Basis: If the orthodontic treatment plan does not show a separate charge for appliance insertion, each monthly benefit will be the total benefit pro-rated over the number of months in the treatment plan.
2. Itemized Charge Basis: If the orthodontic treatment plan includes a separate charge for appliance insertion, the benefit for the first month of treatment will not exceed 25% of the total benefit. Subsequent monthly benefits will then be the balance of the total benefit pro-rated over the number of months remaining in the treatment plan.

The Insurance Company will notify the Insured Person and his or her Dentist of the benefits payable.

DENTAL BENEFITS (Continued)

Orthodontics Benefits (continued)

Benefit Payments (continued)

The Insurance Company has the right to require additional information to determine benefits payable. This includes but is not limited to:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models;
4. completion of a questionnaire that will specify: (a) the degree of overjet, overbite, crowding, or open bite; (b) if teeth are impacted, in crossbite, or congenitally missing; (c) the length of treatment; and (d) the total charge for the treatment.

Late Entrants

A person who is a Late Entrant will not be eligible for Orthodontic Benefits for the first 24 consecutive months he or she is covered under the Policy.

Benefits After Attainment of the Dependent Child Limiting Age

Benefits will continue to be payable for an Insured Person who attains the Dependent Child limiting age, provided:

1. the appliance or bands were inserted while the person was under the limiting age, and covered under the Policy; and
2. he or she otherwise remains eligible for coverage; and
3. orthodontic treatment continues.]

DENTAL EXCLUSIONS

Covered Dental Expenses will not include, and Dental Benefits will not be payable for, the following charges:

1. charges for crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
2. charges for procedures relating to the change of vertical dimension; restoration of occlusion; bite registration; bite analysis; or which are cosmetic in nature;
3. charges for initial placement of full dentures, partial dentures or bridges if it includes the replacement of teeth all of which were missing on the date the Insured Person became covered under this plan. This exception will not apply if the prosthesis replaces a functioning tooth that was removed while covered;
4. charges for replacement of bridges, partial dentures, full dentures, inlays and crowns unless on the date of the replacement: (a) the Insured Person has been covered under the Policy for at least 12 consecutive months; and (b) it has been at least five years since the bridge, denture, inlay or crown was first inserted. This exception will not apply if the replacement is made necessary by: (i) the removal of a functioning natural tooth; or (ii) Covered Dental Injury to sound natural teeth; provided the removal or Injury occurred during the 12 months preceding the replacement;
5. charges for replacement of bridges, partial dentures, full dentures, crowns or inlays if they can be repaired;
6. charges for implants and related services;
7. charges for orthodontic treatment unless otherwise provided in a section of the Policy entitled "Orthodontics Benefits";
8. charges for appointments which are broken or otherwise missed;
9. for which benefits are not payable according to the section of the Policy entitled "General Limitations".]

[VISION CARE BENEFITS

If an Insured Person incurs covered vision care expense, the following benefits are payable.

Covered Vision Care Expenses

Covered Vision Care Expenses are the Reasonable and Customary Charges for each of the services or supplies listed in the Schedule of Vision Care Services and Supplies. Benefits are payable up to the Maximum Allowance that applies to each service or supply. Such services or supplies must be rendered by or recommended and approved by an ophthalmologist or optometrist. The Schedule of Vision Care Services and Supplies and the Maximum Allowances are shown in the Schedule of Benefits.

Vision Care Exclusions

No benefits are payable for:

- [1. charges for more than [one examination in any 12 consecutive month] period;]
- [2. charges for more than [one pair of lenses in any 24 consecutive month] period;]
- [3. charges for more than [one set of frames in any 24 consecutive month] period;]
- [4. charges for sunglasses, unless prescribed to be worn at substantially all times;]
- [5. charges for examinations required by an Employer in connection with employment;]
- [6. charges for any item or service not listed in the Schedule of Vision Care Services and Supplies;]
- [7. charges for services or supplies to the extent that benefits are payable for the services or supplies elsewhere under the Policy;]
- [8. charges for which benefits are not payable according to the section of the Policy entitled "General Limitations".]

[GENERAL LIMITATIONS

No benefits will be payable under the Policy for any of the following:

- [1. charges incurred for, or in connection with an Injury arising out of, or in the course of, any employment for wage or profit, including self-employment;]
- [2. charges incurred for, or in connection with a Sickness for which Insured Person is entitled to benefits under any worker's compensation or similar law;]
- [3. charges for care or treatment of any Sickness or Injury that results from [active participation in] war, declared or undeclared, or [active participation in] any act of war, or committing or attempting to commit an assault or felony or from any intentionally self-inflicted Injury;]
- [4. charges incurred for treatment to the extent that payment under the Policy is prohibited by any law of the jurisdiction in which the Insured Person resides at the time the expenses are incurred;]
- [5. charges which the Insured Person is not legally required to pay or for charges which would not have been made if no insurance coverage had existed;]
- [6. charges for services and supplies which are in excess of the lesser of: (a) the Reasonable and Customary Charge; or (b) the actual charge;]
- [7. charges for services and supplies that are not Medically Necessary;]
8. [charges for non-surgical treatment of Temporomandibular Joint Dysfunction;]
- [9. charges for vitamins or food supplements or for experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances;]
- [10. charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;]
- [11. charges for treatment, services or supplies received in a Hospital owned and operated by any government;]
- [12. charges for private duty nursing services in a Hospital or any other facility;]
- [13. charges in connection with a change in gender;]
- [14. charges incurred by an Insured Person as an organ donor;]
- [15. charges incurred for, or in connection with Custodial Care, education or training;]
- [16. to the extent that the Insured Person is reimbursed, entitled to reimbursement, or is in any way indemnified for those expenses by or through any public program. For the purpose of this paragraph, any individual who, at any time, was entitled to enroll in all or any portion of the medical care program under Title XVIII of the Social Security Act of 1965, as amended (Medicare) but who did not so enroll will be considered to be entitled to reimbursement in an amount equal to the amount to which he or she would have been entitled, if any, if he or she were so enrolled;]
- [17. charges for services rendered by a member of the Insured Person's Immediate Family;]
- [18. charges incurred in connection with the Pregnancy of an Insured Dependent Child;]
- [19. Charges incurred for the treatment of Acquired Immune Deficiency Syndrome (AIDS);]

**GENERAL LIMITATIONS
(Continued)**

[20.charges for a surgical procedure that does not correct the condition of Infertility but is used to induce Pregnancy, such as in-vitro fertilization, artificial insemination or similar procedure;]

[21.charges for reversal of a voluntary surgical sterilization (charges for voluntary surgical sterilizations are covered);]

[22.charges incurred by a Dependent Child who is under 15 days of age, except expenses incurred as a result of (a) abnormal congenital conditions, (b) Sickness or Injury, or (c) premature birth (which means that the child weighed less than 5½ pounds at birth)].

The provision above which indicates that no payment will be made for expenses incurred in connection with Injury arising out of, or in the course of any employment for wage or profit will not apply with respect to any partner, proprietor, or corporate officer who is not himself or herself covered under worker's compensation or similar law.

No payment will be made under the Policy for expenses incurred by an Insured Person to the extent that he or she is reimbursed, entitled to reimbursement or in any way indemnified for those expenses by any personal Injury protection benefits payable under the mandatory portion of any group or individual automobile insurance policy written under the "no-fault" insurance provisions of the law of any jurisdiction.].

[COORDINATION OF BENEFITS]

Applicability. This provision applies to all [vision, dental and medical] benefits under the Policy

This Coordination of Benefits ("COB") provision applies to This Plan when an Insured Person has coverage under more than one Plan. "Plan" and "This Plan" are defined below under "Definitions."

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the Section entitled "Effect on the Benefits of This Plan".

Definitions

"Plan" means any of these which provides benefits or services for the Insured Person:

1. Group or group-type insurance contracts;
2. Group or group-type subscriber contracts;
3. Uninsured arrangements of group or group-type coverage;
4. Group or group-type coverage through health maintenance organizations and other prepayment, group practice and individual practice plans;
5. The medical benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts; and
6. Coverage under a governmental plan or coverage required or provided by law; but not including: (a) 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); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

However, a Plan does not include school accident-type coverage that covers grammar, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

"Group-type" refers to contracts or coverage's that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts and coverage's answering this description are included in the definition of a Plan whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket").

Each contract or other arrangement for coverage described above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"This Plan" means the Policy.

"Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the Insured Person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the Insured Person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means a Medically Necessary, Reasonable and Customary item of expense when such item is covered at least in part by one or more Plans covering the Insured Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year. However, it does not include any part of that period of time during which an Insured Person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

COORDINATION OF BENEFITS (Continued)

Order of Benefit Determination Rules

General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules, described in the Section entitled "Rules" below, require that This Plan's benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The benefits of the Plan which covers the Insured Person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the Insured Person as a Dependent.

Birthday. The Plan which covers an Insured Person as a Dependent of a person whose date of birth occurs earlier in a calendar year will pay before the Plan which covers an Insured Person as a Dependent of a person whose date of birth occurs later in a calendar year; provided:

1. if the other Plan does not have this rule, its alternate rule will govern; and
2. in the case of an Insured Dependent Child of divorced or separated parents, the rule set forth in the section titled Divorce/Separation below will apply.

Divorce/Separation. If there is a court decree which establishes financial responsibility for medical, dental or other health care expenses of a child, the Plan which covers child as a Dependent of the parent so responsible will be determined before any other Plan; otherwise:

1. the benefits of the Plan which covers the child as a Dependent of the parent with custody will be determined before the Plan which covers the child as a Dependent of a stepparent or a parent without custody
2. the benefits of the Plan which covers the child as a Dependent of a stepparent will be determined before the Plan which covers the child as a Dependent of a parent without custody.

Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Insured Person for the longer term are determined before those of the Plan which covered that Insured Person for the shorter term, subject to the following exceptions:

Active/Inactive Employee. The benefits of a Plan which covers an Insured Person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers the Insured Person as a laid off or retired Employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage. If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in this order:

1. First, the benefits of a Plan covering the Insured Person as an Employee, member or subscriber;
2. Second, the benefits under the continuation coverage.

If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

COORDINATION OF BENEFITS (Continued)

Effect of Medicare

If the Insured Person is also a Medicare beneficiary:

1. due to end stage renal disease, This Plan will determine benefits without consideration of Medicare benefits for which the Insured Person is eligible during the first 30 months of his or her eligibility for such Medicare benefits; or
2. due to any other condition, or due to attainment of age 65 or 70, This Plan will determine benefits without consideration of Medicare benefits for which the Insured Person is eligible.

Effect on the Benefits of This Plan

When This Section Applies. This Section applies when, in accordance with the Section entitled "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Insurance Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Insurance Company any facts it needs to pay the claim.

Facility of Payment. A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the Insurance Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Insurance Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Insurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.]

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Insurance Company within [30] days after the occurrence of the event on which the claim is based.

Written notice of claim given by or on behalf of the Insured Employee to the Insurance Company at its Home Office, or to any authorized agent of the Insurance Company, with particulars sufficient to identify the Employee, will be considered notice to the Insurance Company. Failure to give written notice within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as was reasonably possible.

Claim Forms. The Insurance Company, will furnish to person making claim or to the [Participating Employer] [Policyholder] for delivery to such person, the claim forms which it usually furnishes for filing proofs of loss. If such forms are not furnished before the expiration of [15] days after the Insurance Company receives notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proofs of Loss. Written proof of loss must be furnished to the Insurance Company at its Home Office within [365] days after the date of the loss for which claim is made. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Insurance Company may reasonably require. Failure to furnish written proof of loss within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to furnish written proof of loss within that time and that written proof of loss was furnished as soon as was reasonably possible.

Time of Payment of Claims. All benefits payable under the Policy other than benefits for loss of time will be payable not more than [60] days after receipt of proof, and that, subject to proof of loss, all accrued benefits payable under the Policy for loss of time will be paid not less frequently than monthly during the continuance period for which the Insurance Company is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof.

Payment of Claims. Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Employee. If an Insured Employee dies before all payments due have been made, the amount still payable will be paid to his or her estate.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Insurance Company may make an initial payment, up to an amount not exceeding [\$5,000], to any relative by blood or connection by marriage of the payee who is deemed by the Insurance Company to be equitably entitled thereto. Such payment does not discharge the Insurance Company's liability for any remaining benefits payable under the Policy.

All or any portion of the Medical, Dental, or Vision Benefits provided by the Policy may, at the option of the Insurance Company, be paid directly to the individual or institution on whose charges claim is based or to any of the following surviving relatives of the Employee: wife, husband, mother, father, child or children, brothers or sisters; or to the executors or administrators of the Employee.

Any payment the Insurance Company makes in good faith fully discharges the Insurance Company's liability to the extent of the payment made.

Direct Payment of Hospital or Medical Services. All or any portion of any indemnities provided by the Policy on account of Hospital, nursing, medical or surgical services may, at the Insurance Company's option, be paid directly to the Hospital or person rendering such services, but the Policy may not require that the service be rendered by a particular Hospital or person. Payments so made shall discharge the Insurance Company's obligation with respect to the amount of insurance so paid.

GENERAL PROVISIONS

Legal Actions. No action at law or in equity will be brought to recover on the Policy prior to the expiration of [90] days after written proof of loss has been filed in accordance with the requirements of the Policy, nor will any action be brought at all unless brought within [three] years from the expiration of the time within which proof of loss is required by the Policy.

Time Limitations. If any time limitation provided in the Policy for giving notice of claims, for furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the jurisdiction in which the Employee resides at the time the Policy is issued, then the time limitation of the prevailing jurisdiction applies.

Physical Examination and Autopsy. The Insurance Company, at its own expense, will have the right and opportunity to examine any individual for whom claim is pending under the Policy when and as often as it may reasonably require and to make an autopsy in case of death where it is not forbidden by law.

Reimbursement and Subrogation. When an Insured Person's Injury appears to be someone else's fault, benefits otherwise payable under the Policy for covered expenses incurred as a result of that Injury will not be paid unless the Insured Person or his legal representative agrees:

1. to repay the Insurance Company for such benefits to the extent they are for losses for which compensation is paid to the Insured Person by or on behalf of the person at fault;
2. to allow the Insurance Company a lien on such compensation and to hold such compensation in trust for the Insurance Company; and
3. to execute and give to the Insurance Company any instruments needed to secure the rights under (a) and (b).

Further, when the Insurance Company has paid benefits to or on behalf of the injured Insured Person, the Insurance Company will be subrogated to all rights of recovery that the Insured Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Insurance Company has paid. The Insured Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Insurance Company.

NOTICE OF FEDERAL REQUIREMENTS

Coverage for Reconstructive Surgery Following Mastectomy

When a person who is insured for benefits under this Certificate and who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your Employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

[ERISA INFORMATION]

This Employee Benefit Plan (the "Plan"), sponsored by [ABC Industries, Inc.] is intended to comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The following information, together with the information contained in this booklet complies with the Plan Administrator's ERISA disclosure obligations. This information is furnished by the Plan Administrator and is not a part of the Policy. The Policy may be obtained from the Plan Administrator or the Insurer by written request at the addresses listed below.

PLAN NAME: [Employee Benefit Plan]

PLAN NUMBER: [000]

PLAN SPONSOR/PLAN ADMINISTRATOR: [ABC Industries, Inc.
101 N. Main Street
Anytown, DE 19801]

EMPLOYER IDENTIFICATION NUMBER (EIN):[XX-XXXXXX]

PLAN TYPE: This booklet provides information about the Group [Life], [Accidental Death and Dismemberment], [Supplemental Life], [Supplemental Accidental Death and Dismemberment], [Long Term Disability], [Medical], [Dental], and [Vision] Insurance for Employees covered under the Plan and [Dependent Life], [Dependent Accidental Death and Dismemberment], [Medical], [Dental] and [Vision] benefits for Employee's Dependents.

TYPE OF ADMINISTRATION: Insurer administration -
Delaware American Life Insurance Company
600 King Street
Wilmington, DE 19801

PLAN ADMINISTRATION:

The Plan is administered by the Plan Administrator which is the Named Fiduciary for the Plan. The Plan Administrator has discretionary authority to determine the status and rights of participants, beneficiaries and other persons, to construe and interpret Plan terms, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be sufficient to warrant deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire and Rubber Co. v. Bruch.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

ERISA INFORMATION
(Continued)

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Group [Life], [Accidental Death and Dismemberment], [Supplemental Life], [Supplemental Accidental Death and Dismemberment], [Dependent Life], [Dependent Accidental Death and Dismemberment], [Long Term Disability], [Medical], [Dental], and [Vision] Insurance benefits described in this benefit booklet are provided pursuant to an insurance contract issued to [ABC Industries, Inc.] by The Delaware American Life Insurance Company. Delaware American life Insurance Company is the Claims Administrator for these Group [Life], [Accidental Death and Dismemberment], [Supplemental Life], [Supplemental Accidental Death and Dismemberment], [Dependent Life], [Dependent Accidental Death and Dismemberment], [Long Term Disability], [Medical], [Dental], and [Vision] Insurance benefits. The Plan Administrator has delegated to Delaware American Life Insurance Company its entire discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the contract.

WAIVER:

Failure by the Plan or Plan Administrator to insist upon compliance with any provision of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

GOVERNING LAW:

The Plan shall be interpreted under federal law, including ERISA, and by the laws of the State of Delaware, to the extent not preempted.

THE AGENT FOR SERVICE OF LEGAL PROCESS:

[ABC Industries, Inc.
101 N. Main Street
Anytown, DE 19801]

SOURCE OF CONTRIBUTIONS:

[The Employer and Employees share in the cost of this Insurance.] [The Employer pays the cost of this Insurance.]

PLAN YEAR:

The fiscal records of the Plan are kept on a [Plan] [Calendar] year basis, [July 1 through June 30].

ERISA INFORMATION
(Continued)

PLAN MODIFICATION, AMENDMENT AND TERMINATION:

The Insurance Company reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all provisions of the Plan, including termination of the Plan. Amendments to this Plan, or termination of this Plan, are to be made by a written resolution adopted in accordance with the established procedures of the Board of Directors. Amendments may be adopted with retroactive effect to the extent permitted by ERISA and the Code. Any change will affect all covered persons, including Dependents, retirees and disabled individuals.

CLAIM DENIALS AND APPEAL OF DENIED CLAIMS:

If a claim is denied in whole or in part, the covered person will receive a written notification within 90 days from the date the claim was submitted. If additional information is needed for consideration of the claim, the Insurer/Claims Administrator will request it from either the provider of the service or the covered person. If special circumstances warrant an extension of time, a written notice will contain an explanation of the special circumstances necessitating the extension. In no event shall the extension exceed a period of 90 days from the end of the initial period (i.e., 180 days from the date the claim was submitted). For all claims, an explanation of benefits form will be provided by the Insurer/Claims Administrator showing the calculation of the total amount payable, the charges not payable, and the reason for the denial of any charges not covered. If an explanation of why the benefits were denied is not received by the end of the 90 day period (or 180 days if an extension is requested), the claim should be deemed denied.

Any covered person may request a review of the denial of any benefit claim by submitting a written request for review to the Insurer/Claims Administrator. This must be done within 60 days after the denial is received by the covered person (or 60 days from the expiration of the period after which the claim is deemed denied).

Any covered person and/or his authorized representative may examine pertinent documents which the Plan Administrator has and submit opinions and comments. The decision of the Insurer/Claims Administrator regarding a request for a review of a denied claim will be in writing and will be made within 60 days of receiving a request for review of a denied claim, unless special circumstances require an extension of time. If special circumstances warrant an extension of time, a written notice of the extension will be sent prior to the expiration of the original 60 day period. Such notice shall contain an explanation of the special circumstances necessitating the extension. In no event shall the extension exceed a period of 60 days from the end of the initial period (i.e., 120 days from the date of the request for review).

The decision of the Insurer/Claims Administrator will be delivered to the covered person in writing and will set forth the specific reasons for the decision and specific references to pertinent provisions of the Plan on which the decision was based. If a written determination as to the request for review of the denied claim is not received by the end of the 60 day period (or 120 days if an extension is requested), the claim should be deemed denied on review. The decision on review of the Insurer/Claims Administrator will be final.

ERISA INFORMATION
(Continued)

PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Employer and any participant, nor to be consideration or an inducement for the employment of any participant or Employee. Nothing contained in this Plan shall be deemed to give any participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any participant or Employee at any time, subject to the terms of any applicable collective bargaining agreement, regardless of the effect which such discharge shall have upon him as a participant of this Plan.

STATEMENT OF ERISA RIGHTS:

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- (a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (b) Obtain copies of all documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the Plan's annual financial report. The Plan Administrator may be required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit or exercising your rights under ERISA. If your claim for a Welfare Benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquirers, Pension and Welfare Benefit Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.]



**DELAWARE AMERICAN LIFE
INSURANCE COMPANY**

Policyholder: [ABC Incorporated]
[Participating Employer: [XYZ Employer, Inc]]
Policy Number: [XXXXXX]

600 King Street
WILMINGTON, DELAWARE 19801
(302) 594-2000
(Herein called the Insurance Company)

GROUP INSURANCE POLICY AMENDMENT NO.

This Policy Amendment is attached to and made part of the Policy effective _____ at 12:01 a.m. Standard Time at the address of the [Policyholder] [Participating Employer]. Any changes in coverage apply on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

Policy XXXXX

In consideration of timely payment of the required premium, the Policy is amended as follows:

This Policy Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Policy Amendment.

IN WITNESS WHEREOF, Delaware American Life Insurance Company has caused this Policy Amendment to be executed.

ACCEPTED FOR THE [PARTICIPATING] EMPLOYER

DELAWARE AMERICAN LIFE INSURANCE
COMPANY

Signature

Signature

Title

Title

Date

Date