

SERFF Tracking Number: MCHX-G127611042 State: Arkansas  
 Filing Company: 4 Ever Life Insurance Company State Tracking Number: 49697  
 Company Tracking Number: FORM 55.203  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Form 55.202 Business Traveler Blanket Insurance -  
 Project Name/Number: Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company /Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company

## Filing at a Glance

Company: 4 Ever Life Insurance Company

Product Name: Form 55.202 Business Traveler Blanket Insurance - SERFF Tr Num: MCHX-G127611042 State: Arkansas

TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Approved-Closed State Tr Num: 49697

Sub-TOI: H04.000 Health - Blanket Accident/Sickness Co Tr Num: FORM 55.203 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor  
 Author: SPI McHughConsulting Disposition Date: 09/26/2011  
 Date Submitted: 09/01/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval  
 State Filing Description:

Implementation Date:

## General Information

Project Name: Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company Status of Filing in Domicile: Not Filed

Project Number: Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Blanket

Overall Rate Impact:

Filing Status Changed: 09/26/2011

State Status Changed: 09/26/2011

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Re: 4 Ever Life Insurance Company

NAIC No.: 80985

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FEIN: 36-2149353

Business Traveler Program - OUT OF STATE GROUP FILING  
Form 55.203(DE) Supplemental Blanket Travel Plan Certificate  
Form 55.205(AR) Endorsement to Policy/Certificate  
Form 55.201 Supplemental Blanket Travel Plan Participating Organization  
Application/Request to Participate

McHugh Consulting Resources, Inc. has been requested to file the above-referenced forms on behalf of 4 Ever Life Insurance Company. We have provided a letter of authorization for your files.

We are submitting the above captioned forms for your review and approval. These forms are new and not intended to replace any other forms currently in use.

This program provides supplemental blanket travel coverage while a person is temporarily traveling for business internationally either to or from the United States. The plan is supplemental to health insurance under a group plan that does not provide coverage while an insured person is traveling outside of his or her home country.

The policy may be issued to a trust established in Delaware known as the HTH International Group Insurance Trust (Christiana Bank & Trust Company as Trustee) where subscribers to the trust will be employer groups that elect to participate in the trust in accordance with T. 18 §§3502 and 3509. Policy Form 55.202 was approved by Delaware on August 9, 2011. This program will be marketed through agent/broker solicitation and direct solicitation to employer groups.

Endorsement Form 55.205(AR) will be used to bring the policy/certificate into compliance with your state requirements. The appropriate language contained in the endorsement will be used as an attachment to the certificate or it may be included in the body of the certificate, where appropriate.

Supplemental Blanket Travel Plan Participating Organization Application/Request to Participate Form 55.201 will be completed by employer groups participating in the trust.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific college, school or university's request. Variable data will never exclude or limit provisions required by your state.

Printing of all forms is subject to changes in page numbers, margins, positioning and format. Printing standards will never be less than required under your law. Electronic use of this form may result in changes or variations in margins,

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formatting and pagination. However, the text will not be less than ten-point type and the form will meet the readability standards required under your law.

4 Ever Life Insurance Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

Enclosed please find any required certifications and/or transmittal forms. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

Jeanne Heider  
Consultant

Enclosures

## Company and Contact

### Filing Contact Information

Tim Hager, Compliance Project Specialist mcr@mchughconsulting.com  
McHugh Consulting Resources, Inc. 215-230-7960 [Phone]  
2005 South Easton Road, Suite 207 215-230-7961 [FAX]  
Doylestown, PA 18901

### Filing Company Information

(This filing was made by a third party - McHughConsulting)

4 Ever Life Insurance Company	CoCode: 80985	State of Domicile: Illinois
2 Mid America Plaza	Group Code:	Company Type:
Suite 200	Group Name:	State ID Number:
Oakbrook Terrace , IL 60181	FEIN Number: 36-2149353	
(630) 472-7726 ext. [Phone]		

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00

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Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
4 Ever Life Insurance Company	\$150.00	09/01/2011	51205239

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/26/2011	09/26/2011

### 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	09/09/2011	09/09/2011	SPI McHughConsulting	09/21/2011	09/21/2011

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## Disposition

Disposition Date: 09/26/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document	Dual Filing Letter	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	09.21.11 Resubmission Letter	Approved-Closed	Yes
Form	Supplemental Blanket Travel Plan Certificate	Approved-Closed	Yes
Form (revised)	Endorsement to Policy/Certificate	Approved-Closed	Yes
Form	Endorsement to Policy/Certificate	Replaced	Yes
Form	Supplemental Blanket Travel Plan Participating Organization Application/Request to Participate	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 09/09/2011  
Submitted Date 09/09/2011  
Respond By Date 10/09/2011

Dear Tim Hager,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Supplemental Blanket Travel Plan Certificate, Form 55.203(DE) (Form)

Comment:

Under Eligible Dependent, Handicapped Dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-102(8) and Bulletin 14-81.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

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 09/21/2011  
 Submitted Date 09/21/2011

Dear Rosalind Minor,

### Comments:

We are in receipt of your objection letter dated 09/09/11. This is in response to your concerns.

### Response 1

Comments: Please find attached the response to your objection letter.

### Related Objection 1

Applies To:

- Supplemental Blanket Travel Plan Certificate, Form 55.203(DE) (Form)

Comment:

Under Eligible Dependent, Handicapped Dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-102(8) and Bulletin 14-81.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: 09.21.11 Resubmission Letter

Comment:

#### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Endorsement to Policy/Certificate	Form 55.205(AR)		Certificate Amendment, Insert Page, Endorsement or Rider	Revised		40.000	AR 4EL Business Traveler Endorsement

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**Previous Version**

Endorsement to	Form	Certificate Amendment, Initial	40.000	AR 4EL
Policy/Certificate	55.205(AR	Insert Page, Endorsement		Business
	)	or Rider		Traveler
				Endorsement
				ent
				CLEAN
				8_2011.P
				DF

No Rate/Rule Schedule items changed.

Thank you for your time and consideration of this filing.

Sincerely,  
 SPI McHughConsulting

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/26/2011	Form 55.203(DE)	Certificate	Supplemental Blanket Travel Plan Certificate	Initial		40.000	DE 4EL BT Trust Health Cert CLEAN 8_24_2011.PDF
Approved-Closed 09/26/2011	Form 55.205(AR)	Certificate	Endorsement to Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: Previous Filing #:	40.000	AR 4EL Business Traveler Endorsement CLEAN 9_2011.PDF
Approved-Closed 09/26/2011	Form 55.201	Application/ Enrollment Form	Supplemental Blanket Travel Plan Participating Organization Application/Request to Participate	Initial		40.000	4EL BT DE Trust Application Form 7_13_11 CLEAN.PDF

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

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

**[Business Traveler]**

Supplemental Blanket Travel Plan

Policy Holder: [Participating Organization Name]

Certificate of Coverage: [Policy Number]

Effective Date: [Policy Effective Date]

This Plan provides medical benefits while a person is temporarily away from Home. This Plan is supplemental to health insurance under a group plan that does not provide coverage while the Insured Person is outside their Home Country. It is not subject to the guaranteed renewability and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Insured Person may not purchase insurance under this Plan for a Period of Insurance longer than <180 – 364> days.

The Insurance Coverage Area is any place that is [within the United States] [outside the United States] [anywhere in the world].



SECRETARY



HFBucham, III  
PRESIDENT

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## I. Introduction

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### About This Plan

This Certificate of Coverage is issued by 4 Ever Life Insurance Company ("Insurer") through a policy issued to [HTH International Group Insurance Trust].

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

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

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

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

**Choice of Hospital and Physician:** Nothing contained in this Plan restricts or interferes with the Eligible Participant's right to select the Hospital or Physician of the Eligible Participant's choice. Also, nothing in this Plan restricts the Eligible Participant's right to receive, at his/her expense, any treatment not covered in this Plan.

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

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

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

#### A. BlueCard® Program

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

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

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

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

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

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

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

1. Member Liability Calculation

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

2. Exceptions

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

**Use of Administrator:** The Insurer may use a third party administrator to perform certain of the Insurer's duties on the Insurer's behalf. The Group and the Insured Participant will be notified of the use of an administrator.

**Benefit Overview Matrix**

Following is a very brief description of the benefit schedule of the Plan. This should be used only as a quick reference tool. The entire Certificate of Coverage sets forth, in detail, the rights and obligations of both the Insured Person and the Insurer. It is, therefore, important that **THE ENTIRE CERTIFICATE OF COVERAGE BE READ CAREFULLY!**

The benefits outlined in the following table show the payment percentages for Covered Expenses AFTER the Insured Person has satisfied any Deductibles and prior to satisfaction of his/her Out-of-Pocket. **Covered Expenses are based on Reasonable Charges which may be less than actual billed charges. Providers can bill the Insured Person for amounts exceeding Covered Expenses.**

**Deductible:**

The Insured Person's Deductible is <\$0 - \$25,000> per Insured Person per {Trip Coverage Period / Period of Insurance}.

**Copayment:**

The Insured Person's Copayment is listed below and is based upon each visit for medical services.]

**After the Deductible is satisfied [and/or Copayment paid by Insured Person], benefits are paid for Covered Expenses as follows:**

**BENEFIT OVERVIEW MATRIX**

<b>Policy Maximums</b>	<b>Insurer pays up to Per Insured Person</b>
<b>[Trip Period Maximum Benefits</b>	<\$10,000 - \$1,000,000>]
<b>[Period of Insurance Maximum Benefits</b>	<\$10,000 - \$1,000,000>]
<b>Out of Pocket maximums (Insured Person Pays)</b>	<b>Insurer pays</b>
<b><u>First Level Payment</u></b> Until the Insured Person incurs <\$0 - \$100,000> in Out-of-Pocket Expenses per {Trip Coverage Period / Period of Insurance}	<50% - 100%>
<b><u>Second Level Payment</u></b> Once the Insured Person incurs <\$0 - \$100,000> in Out-of-Pocket Expenses per {Trip Coverage Period / Period of Insurance}	100%
<b>Benefits</b>	<b>Insurer pays</b>
<b>Professional Services</b> a. Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab [If these services are performed by a Provider participating in the HTH International Healthcare Community, the Deductible is Waived[ and the Insured Person pays a <\$10 - \$50> Copayment for each visit].]	<50% - 100%>
b. Office Visits: including X-rays and lab work billed by the attending physician. [If these Physician services are performed by a Provider participating in the HTH International Healthcare Community, the Deductible is Waived[ and the Insured Person pays a <\$10 - \$50> Copayment for each visit].]	<50% - 100%>]
<b>Inpatient Hospital Services</b>	
a. Surgery, X-rays, In-hospital doctor visits [If these in-patient Hospital services are performed by a Provider participating in the HTH International Healthcare Community, the Deductible is Waived[ and the Insured Person pays a <\$50 - \$250> Copayment for each visit].]	<50% - 100%>

Policy Maximums	Insurer pays up to Per Insured Person
<p>b. In-patient medical emergency            [If these in-patient Hospital services are performed by a Provider participating in the HTH International Healthcare Community, the Deductible is Waived [and the Insured Person pays a &lt;\$50 - \$250&gt; Copayment for each visit].]</p>	<50% - 100%>]
<p><b>Ambulatory Surgical Center</b>            [If these Hospital and outpatient Physician services are performed by a Provider participating in the HTH International Healthcare Community, the Deductible is Waived [and the Insured Person pays a &lt;\$0 - \$250&gt; Copayment for each visit].]</p>	<50% - 100%>]
<p><b>[Ambulance Service (non Medical Evacuation)</b></p>	<50% - 100%> up to <\$100 - \$1,000>]
<p><b>[Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor)</b></p>	Limited to [Period of Insurance Maximum] [Trip Period Maximum] [or] [\$5,000 - \$25,000] [whichever is less].]
<p><b>[Medical treatment arising from participation in [intercollegiate,] [interscholastic] [,club] [,amateur] or [professional] sports competitions, practices, or training</b></p>	Reasonable Expenses up to <\$1,000 - \$1,000,000> Maximum per {Policy Year / lifetime / Injury or Sickness}}
<p><b>[Medical treatment arising from participation in [Racing or speed contests,] [skin/scuba diving], [sky diving], [mountaineering (where ropes are customarily used)], [ultra light aircraft], [parasailing], [sail planning], [hang gliding], [bungee jumping], [travel in or on ATV's (all terrain or similar type vehicles)].]</b></p>	Reasonable Expenses up to <\$1,000 - \$1,000,000> Maximum per {Trip Period / Period of Insurance}}
<p><b>[Medical treatment received in the Home Country [, if NOT covered by Other Plan]</b>  <b>[Same provisions apply for Professional Services, In Patient Hospital Services and Ambulatory Surgical Centers, if the HTH International Healthcare Community providers are used.]</b></p>	<50% - 100%> of Covered Expenses up to <\$250 - \$100,000> maximum per {Trip Period / Period of Insurance}}
<p><b>[In the {U.S. / Home Country} ]Outpatient prescription drugs</b></p>	{<50% - 100%> of Covered Expenses / Not Covered}.
<p><b>[{Outside the U.S. / Outside Home Country} Outpatient prescription drugs</b></p>	{<50% - 100%> of Covered Expenses / Not Covered}.
<p><b>[Dental Care required due to an Injury</b></p>	<50% - 100%> of Covered Expenses up to <\$50 – \$1,000> with maximum per {Trip Period / Period of Insurance} and <\$50 – \$200> per tooth]
<p><b>[Dental Care for Relief of Pain</b></p>	<50% - 100%> of Covered Expenses up to <\$50 – \$1,000> per {Trip Period / Period of Insurance} and <\$50 - \$200> per tooth ]
<p><b>[Physical and/or Occupational Therapy/Medicine</b></p>	Maximum payment of <\$0 - \$50> per visit and maximum of <6-24> visits per Period of Insurance]
<p><b>[Accidental Death &amp; Dismemberment</b></p>	[Maximum Benefit: [Principal Sum up to [<\$1,000 - \$1,000,000 for Eligible Participant;] [Principal Sum up to [<\$1,000 - \$1,000,000 for Eligible Dependent]]
<p><b>[Accidental Death &amp; Dismemberment</b></p>	[Maximum Benefit: Principal Sum up to < 1 – 5> times <b>Annual Salary</b> for Eligible Participant with a minimum benefit of <\$25,000 - \$50,000> and a maximum benefit of <\$50,000 - \$1,000,000>.] [Principal Sum up to <\$1,000 - \$1,000,000 for each Eligible Dependent]
<p><b>[Repatriation Of Remains</b></p>	Deductible is not applicable. Maximum Benefit up to {<\$1,000 - \$100,000> / the Cost of the Repatriation}}

Policy Maximums	Insurer pays up to Per Insured Person
[Medical Evacuation]	Deductible is not applicable. Maximum Benefit per {Trip Period / Period of Insurance} for all Evacuations up to {<\$10,000 - \$1,000,000> / the Cost of Evacuation}]
[Bedside Visit]	Deductible is not applicable. Maximum Benefit per {Trip Period / Period of Insurance} up to <\$500 - \$5,000> for the {cost / purchase} of one economy round-trip air fare ticket to [, and the hotel accommodations in,] the place of the Hospital Confinement for one (1) person]

## II. Who is eligible for coverage?

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Eligible Participants [and their Eligible Dependents] are the only people qualified to be covered by the Group's Policy. The following section describes who qualifies as an Eligible Participant or Eligible Dependent, as well as information on when and who to enroll and when coverage begins and ends.

### Who is Eligible to Enroll Under This Plan?

#### An Eligible Participant:

1. Is a member or employee of a Group covered under the Policy.
2. Has submitted an enrollment form, if applicable, and the premium to the Insurer.
3. [Is a bona fide member in good-standing of a membership Group. [An Eligible Participant also includes employees of the Group.]]

#### [Eligible Dependents

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

1. [spouse]; [partner];
2. unmarried natural child, stepchild or legally adopted child who has not yet reached age <24 – 26>;
3. own or spouse's own unmarried child, of any age, enrolled prior to age <19 – 26>, who is incapable of self support due to continuing mental retardation or physical disability and who is chiefly dependent on the Eligible Participant. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's <19<sup>th</sup> – 26<sup>th</sup>> birthday and annually thereafter;
4. unmarried child, from their 19<sup>th</sup> to their <19<sup>th</sup> – 26<sup>th</sup>> birthday who is a full-time student attending an accredited college, university, vocational or technical school, and who is fully dependent upon the Eligible Participant for support. The Insurer may require proof of student status, but not more than once a Period of Insurance;
5. For a person who becomes an Eligible Dependent (as described below) after the date the Eligible Participant's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:
  - a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
  - b. Adopted Children: An Insured Participant's adopted child is automatically covered for Illness or Injury for 31 days from either date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. To continue coverage beyond 31 days, an Insured Participant must enroll the adopted child within 31 days either from the date of placement or the final decree of adoption.
  - c. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is spouse or minor child, coverage will be automatic for the first 31 days following the date which the court order is issued. To continue coverage beyond 31 days, and Insured Participant must enroll the Eligible Dependent within that 31 day period[.].
6. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.]

[As used above[.]:

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

A person **may not** be an Insured Dependent for more than one Insured Participant.]

**[Additional Requirements for an Insured Person: An Insured Person must meet all of the following requirements:**

1. [Home Country is the U.S.]
2. [resident of the U.S. for at least 3 consecutive months]
3. [not a resident of the U.S.]
4. [his/her Home Country is not the U.S.]
5. [under Age <60 – 85>].
6. [enrolled in a Primary Plan.]
7. [Is traveling outside the U.S. or is traveling at least <50 – 500> miles from his/her Home and is scheduled to spend at least <24 – 96> hours away from his/her Home.]
8. [Eligible Dependents must be traveling with the Eligible Participant]
9. [For children under age 6, must be enrolled with a parent.]
10. [Initial purchase must be made in home country prior to departing on trip.]]

**Application and Effective Dates**

The Coverage for an Insured Person will become effective if the individual qualifies as an Eligible Participant of the Group, and the Group and/or the Eligible Participant pays the Insurer the premium. The Effective Date of the Coverage under the Plan is indicated as follows:

**Period of Insurance:** Each Eligible Participant's and his/her Eligible Dependent's Period of Insurance starts on the latest of the following:

1. The Policy Effective Date; or
2. 12:00:01 am on the date designated by the Group of which the Eligible Participant is a member.

**Trip Coverage Start Date:** The Insured Person's coverage under the Policy for a trip during the Period of Insurance starts as stated below:

1. For a scheduled [business] trip [or sojourn] to a Foreign Country, when the Insured Person boards a conveyance at the start of the trip.
2. [For any other trip, when the Insured Person is more than <50 - 500> miles from his/her Home. Notwithstanding the foregoing, no coverage is in effect for a trip unless the Insured Person is scheduled to spend at least <24 – 96> hours away from Home.]

**An Insured Person is eligible for benefits during his/her Period of Insurance ONLY during the Trip Coverage Period.**

In no event will an Eligible Dependent's coverage become effective prior to the Insured Participant's Effective Date of Coverage.

**How Period of Insurance Coverage Ends**

**Insured Persons**

The Insured Person's coverage ends without notice from the Insurer on the earlier of:

1. the end of the last period for which premium payment has been made to the Insurer;
2. the date the Policy terminates;
3. the date the Maximum {Trip Coverage Period / Period of Insurance} Benefit of the Plan has been exhausted;
4. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision.

**Trip Coverage End Date:** The Insured Person's coverage under the Plan for a trip during the Period of Insurance ends as stated below:

1. For a scheduled [business] trip [or sojourn] to a Foreign Country, when the Insured Person alights from a conveyance at the completion of the trip.
2. [For any other trip, when the Insured Person is less than <50 - 500> miles from his/her Home.]
3. On the Period of Insurance Termination Date. However, if the Insured Person has not canceled his/her coverage, then coverage for a trip will extend past the Period of Insurance Termination Date if the Insured Person's return is delayed by unforeseeable circumstances beyond his/her control. In this event, coverage will terminate as stated immediately above or, if earlier, 11:59 p.m. on the seventh day following the Period of Insurance Termination Date.
4. If the Insured Person is covered under the Medical Evacuation Benefit, upon the Insured Person's evacuation to {his/her Home Country / the U.S. / his/her Home Area}.

In no event will coverage for a trip extend past the Maximum Trip Coverage Period stated below, subject to 3 immediately above and as stated in the benefit provisions.

**Maximum Trip Coverage Period:** Coverage for any one trip may not exceed <30 - 364> days.

**Group and Insurer**

The coverage of all Insured Persons shall terminate if the Policy is terminated. If the Insurer terminates the Policy then the Insurer will notify the Group of cancellation. In addition, the Policy may be terminated by the Group on any premium due date. It is the Group's responsibility to notify all Insured Participants in either situation.

The Policy may be terminated by the Insurer:

1. for non-payment of premium;
2. on the date of fraud or intentional misrepresentation of a material fact by the Group, except as indicated in the Time Limit on Certain Defenses provision;
3. on any premium due date for any of the following reasons. The Insurer must give the Group written notice of cancellation at least 30 days in advance if termination is due to:
  - a. failure to maintain the required minimum premium contribution;
  - b. failure to provide required information or documentation related to the Primary Plan or Other Plan upon request.
4. on any premium due date if the Insurer is also canceling all supplemental blanket travel plans in the state. The Insurer must give the Group written notice of cancellation:
  - a. at least 180 days in advance; and
  - b. again at least 30 days in advance.

**Extension of Benefits**

No benefits are payable for medical treatment benefits after the Policy Holder's insurance terminates. However, if an Insured Person is in a Hospital on the date the insurance policy terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date the confinement ends, the Trip Coverage Period ends, or 31 days after the date the insurance terminates.

### III. Definitions

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The following definitions contain the meanings of key terms used in this Plan. Throughout this Plan, the terms defined appear with the first letter of each word in capital letters.

**Accidental Injury** means an accidental bodily Injury sustained by an Insured Person which is the direct cause of a loss independent of disease, bodily infirmity, or any other cause.

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

**Ambulatory Surgical Center** is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It also must meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

**[Annual Salary** is Eligible Participant's annual base salary, before exercise of any salary reduction option, as of the time of the Accident. Salary will not include over-time earnings, bonus or commission or other compensation not listed in this summary.]

**Certificate of Coverage** is the document issued to each Eligible Participant outlining the benefits under the group Policy.

**Coinsurance** is the percentage of Covered Expenses the Insured Person is responsible for paying (after the applicable Deductible is satisfied [and/or Copayment paid]). **Coinsurance does not include charges for services that are not Covered Services or charges in excess of Covered Expenses. These charges are the Insured Person's responsibility and are not included in the Coinsurance calculation.**

**Complications of Pregnancy** are conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompression, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. Complications of Pregnancy do not include elective abortion, elective cesarean section, false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

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

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

**Cosmetic and Reconstructive Surgery. Cosmetic Surgery** is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Reconstructive Surgery** is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

The **Coverage Period Maximum Benefit** is the maximum amount of benefits available to each Insured Person during the person's Coverage Period (Period of Insurance and/or Trip Coverage Period). All benefits furnished are subject to these maximum amounts.

**Covered Expenses** are the expenses incurred for Covered Services. **Covered Expenses** for Covered Services will not exceed Reasonable Charges. In addition, Covered Expenses may be limited by other specific maximums described in this Plan under section IV, How the Plan Works and section V, Benefits: What the Plan Pays. Covered Expenses are subject to applicable Deductibles, penalties and other benefit limits. **An expense is incurred on the date the Insured Person receives the service or supply.**

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

**Custodial Care** is care provided primarily to meet the Insured Person's personal needs. This includes help in walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of a medical professional.

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

**Dental Protheses** are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

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

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

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

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

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

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

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

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

**Foreign Country** is a country other than the Insured Person's Home Country.

**Foreign Country Provider** is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America. A Foreign Country Provider may also be a supplier of medical equipment, drugs, or medications. [HTH] provides Insured Persons with access to a database of Foreign Country Providers.

A **Full Time Student** is a student enrolled at an accredited college, university, or trade school participating in the Federally Guaranteed Student Loan Program. The student must be currently attending classes, carrying at least 12 units per term.

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

**[Group Health Benefit Plan** means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provided by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota share, or similar basis.]

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

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of Physicians. It must:

1. be licensed as a hospital and operated pursuant to law; and

2. be primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
4. be an institution which maintains and operates a minimum of five beds; and
5. have X-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, those primarily affording custodial care or educational care.

[HTH means Highway to Health (d/b/a HTH Worldwide). This is the entity that provides the Insured Person with access to online databases of travel, health, and security information and online information about physicians and other medical providers.]

[HTH International Healthcare Community consists of physicians, dentists, mental health professionals, other allied health professionals, hospitals, health systems and medical practices countries throughout the world, all dedicated to providing high quality medical care to international travelers, employees and students. The providers are accessed through the HTH online database or through the HTH customer services.]

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

**Injury** (See Accidental Injury)

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

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

**Insured Participant** is the Eligible Participant who is covered under this Plan.

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

**The Insurer** means 4 Ever Life Insurance Company, a nationally licensed and regulated insurance company. Insurer also includes a third party administrator with which the Insurer has contracted to perform certain of its duties on its behalf. The Group and the Insured Participant will be notified of the use of an administrator.

**Investigative Procedures** (See Experimental/Investigational).

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

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

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

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

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

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

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

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

**Out-of-Pocket Maximum** is the amount of Coinsurance each Insured Person incurs for Covered Expenses in a Period of Insurance. The Out-of-Pocket **does not** include any amounts in excess of Covered Expenses, the Deductible, [any Copayments,] any penalties, or any amounts in excess of other benefit limits of this Plan.

The **Period of Insurance Maximum Benefit** is the maximum amount of benefits available to each Insured Person during the person's Period of Coverage. All benefits furnished are subject to this maximum amount.

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

A **Physician** means a physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state and/or country the Insured Person resides or is treated; and provides services covered by the Plan that are within the scope of his/her licensure.

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

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

**[Pre-existing Condition** means a medical condition for which medical advice or treatment was received during the 6 months immediately preceding the Insured Person's Trip Coverage Start Date.]

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

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

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

**Reconstructive Surgery** (See Cosmetic and Reconstructive Surgery)

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

**Totally Disabled or Total Disability means:**

1. As applied to an Insured Participant, any period of time during the Insured Participant's lifetime in which he/she is unable to perform substantially all the duties required by his/her usual occupation, provided the disability commences within twelve (12) months from the date the disabling condition occurred;
2. As applied to a Dependent, not being able to perform the normal activities of a like person of the same age and sex.

**The patient must be under the care of a Physician.**

The **Trip Coverage Period Maximum Benefit** is the maximum amount of benefits available to each Insured Person during the person's Trip Coverage Period. All benefits furnished are subject to this maximum amount.

**U.S.** means the United States of America.

## IV. How the Plan Works

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The Insured Person's Plan pays a portion of his/her Covered Expenses after he/she meets his/her Deductible for each Period of Insurance [or pays his/her Copayment]. This section describes the Deductible [and Copayments] and discusses steps to take to ensure that he/she receives the highest level of benefits available under this Plan. See Definitions (Section III) for a definition of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred by the Insured Person while covered under this Plan. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Plan, which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending the Insurer properly completed claim forms itemizing the services or supplies received and the charges.

### Benefits

This Benefits section shows the maximum Covered Expense for each type of provider.

No benefits are payable unless the Insured Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Plan.

Note: Injuries and Illnesses resulting from terrorism and pandemics are covered as any other Injury or Illness.

### Hospitals, Physicians, and Other Providers

The amount that will be treated as a Covered Expense for services provided by a Provider will not exceed the lesser of actual billed charges or a Reasonable Charge as determined by the Insurer.

**Exception:** If Medicare is the primary payer, Covered Expense does not include any charge:

1. By a Hospital in excess of the approved amount as determined by Medicare; or
2. By a Physician or other provider, in excess of the lesser of the maximum Covered Expense stated above; or
  - a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
  - b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

The Insured Person will always be responsible for any expense incurred which is not covered under this Plan.

### Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. The Period of Insurance Deductible applies to all Covered Expenses. Only Covered Expenses are applied to the Deductible. Any expenses the Insured Person incurs in addition to Covered Expenses are never applied to any Deductible.

Deductibles will be credited on the Insurer's files in the order in which the Insured Person's claims are processed, not necessarily in the order in which he/she receives the service or supply.

If the Insured Person submits a claim for services which have a maximum payment limit and his/her Period of Insurance Deductible is not satisfied, the Insurer will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

### Period of Insurance Deductible

The Insured Person's Period of Insurance Deductible is <\$0 - \$25,000> per Insured Person per Period of Insurance. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received. [The Period of Insurance Deductible does not apply to those services for which a Copayment is required.]

### [Copayments

Copayments are fixed amounts of Covered Expenses the Insured Person owes the provider and which the Insurer will not pay. Copayments are not included as a part of Coinsurance. Copayments are not a part of the calculations of the Out-of-Pocket Maximums.]

### Out-of-Pocket Maximums

The Out-of-Pocket Maximum is the amount of Coinsurance each Insured Person incurs for Covered Expenses in a Period of Insurance. The Out-of-Pocket Maximum **does not** include any amounts in excess of Covered Expenses, Period of Insurance Deductible, [Copayments,] amounts applied to any penalties, or any amounts in excess of other benefit limits of this Plan.

Once an Insured Person incurs <\$0 - \$100,000> Out-of-Pocket in a Period of Insurance, he/she will no longer have to pay any Coinsurance for the remainder of the Period of Insurance.

### Plan Payment

**After the Insured Participant satisfies any required Deductible [and/or Copayment],** payment of Covered Expenses is provided as defined below:

### Limited Benefits

Regardless of the Insured Person's Out-of-Pocket Maximum, the Insurer pays:

1. [For Ambulance Service (non Medical Evacuation), <50% - 100%> up to <\$100 - \$1,000>.]
2. [Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor) that are Limited to the [Period of Insurance Maximum] [Trip Period Maximum] [or] [\$5,000 - \$25,000] [whichever is less].]
3. [For Medical treatment received in the Home Country [ , if NOT covered by Other Plan] <50% - 100%> of Covered Expenses up to <\$250 - \$500,000> maximum per {Trip Period / Period of Insurance};]
4. [In the {U.S. / Home Country} ], for Outpatient prescription drugs <50% - 100%> of Reasonable Charges for Covered Expenses;]
5. [{Outside the U.S. / Outside Home Country} for Outpatient prescription drugs <50% - 100%> of Reasonable Charges for Covered Expenses;]
6. [Dental Care required due to an Injury, <50% - 100%> of Covered Expenses up to <\$50 – \$1,000> with maximum per {Trip Period / Period of Insurance} and <\$50 – \$200> per tooth;]
7. [Dental Care for Relief of Pain, <50% - 100%> of Covered Expenses up to <\$50 – \$1,000> per {Trip Period / Period of Insurance} and <\$50 - \$200> per tooth ].

### For all other Covered Expenses

#### First Level Payment

Until an Insured Person satisfies his/her Out-of-Pocket Maximum for the Period of Insurance, the Insurer pays:

1. <50% - 100%> of the Reasonable Charge for Covered Expense for Office Visits.
2. <50% - 100%> of the Reasonable Charge for the Covered Expense for all other Covered Services. The Insured Person pays <0% - 50%> of the Covered Expense, plus any amount in excess of the Covered Expense and in excess of the Reasonable Charge for the Covered Expense.

#### [Second Level Payment

Once an Insured Person satisfies his/her Out-of-Pocket Maximum in a Period of Insurance, the Insurer pays 100% of the Reasonable Charges for all other Covered Expenses.]

#### [Period of Insurance Maximum Benefits

The combined total of all medical benefits paid to the Insured Person is limited to a maximum of <\$10,000 - \$1,000,000> during each Insured Person's Period of Insurance, so long as the Insured Participant or the Insured Dependent remains insured under this Plan.]

#### [Trip Coverage Period Maximum Benefits

The combined total of all medical benefits paid to the Insured Person is limited to a maximum of <\$10,000 - \$1,000,000> during each Trip Coverage Period for each Insured Person, so long as the Insured Participant or the Insured Dependent remains insured under this Plan and so long as the cumulative amount of paid benefits for all Trip Coverage Periods within the Period of Insurance does not exceed the Period of Insurance Maximum.]

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

## V. Benefits: What the Plan Pays

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Before this Plan pays for any benefits, the Insured Person must satisfy his/her Period of Insurance Deductible. After the Insured Person satisfies the Deductible, the Insurer will begin paying for Covered Services as described in this section.

The benefits described in this section will be paid for Covered Expenses incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all terms, conditions, exclusions, and limitations of this Plan. All services are paid at percentages and amounts indicated below or in the Benefit Overview Matrix, and subject to limits outlined in Section IV, How the Plan Works.

Following is a general description of the supplies and services for which the Insured Person's Plan will pay benefits, if such supplies and services are Medically Necessary:

### Services and Supplies Provided by a Hospital

For any eligible condition [other than/including] for Mental, Emotional or Functional Nervous Conditions or Disorders, Alcoholism or Drug Abuse, the Insurer will pay indicated benefits on Covered Expenses for:

1. Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
2. Outpatient services and supplies including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.

Payment of Inpatient Covered Expenses are subject to these conditions:

1. Services must be those which are regularly provided and billed by the Hospital.
2. Services are provided only for the number of days required to treat the Insured Person's Illness or Injury

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

### Professional and Other Services

The Insurer will pay Covered Expenses for:

1. Services of a Physician.
2. Services of an anesthesiologist or an anesthetist.
3. Outpatient diagnostic radiology and laboratory services.
4. Surgical implants.
5. Artificial limbs or eyes.
6. The first pair of contact lenses or the first pair of eyeglasses when required as a result of a covered eye surgery.
7. Self-Administered injectable drugs.
8. Syringes when dispensed with self-administered injectable drugs (except insulin).
9. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
10. Services for the detection and prevention of osteoporosis for qualified individuals.
11. Rental or purchase of medical equipment and/or supplies that are **all** of the following:
  - a. ordered by a Physician;
  - b. of no further use when medical need ends;
  - c. usable only by the patient;
  - d. not primarily for the Insured Person's comfort or hygiene;
  - e. not for environmental control;
  - f. not for exercise; and
  - g. manufactured specifically for medical use.

**Note:** Medical equipment and supplies must meet **all** of the above guidelines in order to be eligible for benefits under this Plan. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. The Insurer determines whether the item meets these conditions. Rental charges that exceed the reasonable purchase price of the equipment are not covered.

### Ambulance Services

The following ambulance services are covered under this Plan:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or air service for transportation to and from a Hospital.
2. Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.

### Dental Care for an Accidental Injury

Benefits are payable for dental care for an Accidental Injury to natural teeth that occurs while the Insured Person is covered under this Plan, subject to the following:

1. services must be received during the six months following the date of Injury;
2. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury; and
3. damage to natural teeth due to chewing or biting is not considered an Accidental Injury under this Plan.

In addition, the Plan provides benefits for up to three days of Inpatient Hospital services when a Hospital stay is ordered by a Physician and a Dentist for dental treatment required due to an unrelated medical condition. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

**[Dental Care for Relief of Pain]**

Benefits are payable for dental care for Relief of Pain to the teeth that occurs while the Insured Person is covered under this Plan. Services must be received while covered during the Trip Coverage Period. The Insurer pays as stated in the Benefit Overview Matrix.]

**Complications of Pregnancy**

Complications of Pregnancy are covered under this Plan as any other medical condition. Benefits for complications of pregnancy shall be provided for all Insured Persons.

**[Physical and/or Occupational Therapy/Medicine]**

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable **only** for services rendered by a Physician up to the maximum amounts and visits as stated in the Benefit Overview Matrix. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.]

**Treatment received from Foreign Country Providers**

Benefits for services and supplies received from Foreign Country Providers are covered. The Insured Person may seek the assistance of [HTH] in locating a provider.

**[Benefits for Claims resulting from downhill skiing and scuba diving]**

The Insurer will pay Covered Expenses for claims resulting from downhill (alpine) skiing. It will also pay Covered Expenses resulting from scuba diving provided that the diver is certified by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI), or provided that he/she is diving under the supervision of a certified instructor. These Covered Expenses are Limited as stated in the Benefit Overview Matrix.]

**[Benefits for Claims resulting in [intercollegiate,] [interscholastic] [,club] [,amateur] or [professional] sports competitions, practices, or training]**

The Insurer will pay Covered Expenses as stated in the Benefits Overview Matrix.]

**[Medical treatment arising from participation in [Racing or speed contests,] [skin diving], [sky diving], [mountaineering (where ropes are customarily used)], [ultra light aircraft], [parasailing], [sail planning], [hang gliding], [bungee jumping], [travel in or on ATV's (all terrain or similar type vehicles)].]**

The Insurer will pay Covered Expenses as stated in the Benefits Overview Matrix.

**[Accidental Death & Dismemberment Benefit]**

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

<b>Loss</b>	<b>Benefit</b>
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Insured Person due to any one Accident.

The Principal Sum is stated in Benefit Overview Matrix.

Benefits payable are subject to the Exclusions and Limitations as listed in this document.]

**[Aggregate Limitation.** The total liability hereunder for deaths and Injuries suffered by any number of Insured Persons in any Period of Insurance is <\$1,000,000 - \$10,000,000>. In the event of any such Accident or disaster for which an otherwise payable indemnity would otherwise exceed the amount of the Aggregate Limitation, the indemnity payable will be reduced to the extent that the total of all indemnities payable during the Period of Insurance shall not exceed <\$1,000,000 - \$10,000,000>.]

**[Catastrophic Limitation.** Except as may otherwise be provided, the total liability hereunder for deaths and injuries suffered by any number of Insured Persons in any one Accident or disaster shall not exceed the sum of <\$300,000 - \$5,000,000>. In the event of any such Accident or disaster for which all indemnities payable hereunder would otherwise exceed <\$300,000 - \$5,000,000> the amount of indemnity payable for each Insured Person will be proportionately reduced to the extent that the total of all indemnities payable shall not exceed <\$300,000 - \$5,000,000>.]

#### **[Repatriation of Remains Benefit**

If an Insured Person dies, [while {traveling / living} outside of his/her home country [{for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]}], the Insurer will pay the necessary expenses actually incurred[, up to the Maximum Limit shown in the Schedule of Benefits,] for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

No benefit is payable if the death occurs after the Termination Date of the Policy. [However, if the Insured Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Insured Person's Confinement ends or 31 days after the Termination Date.] The Insurer will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

[This benefit is available only to Insured Persons who are living outside of their Home Country]

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

#### **[Medical Evacuation Benefit**

If an Insured Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services ], [while {traveling / living} outside of his/her home country [{for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]}], and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the {nearest appropriate / the Insured Person's choice of} medical facility. This medically-supervised evacuation will be to the {nearest / the Insured Person's chosen} medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Insured Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services. Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Insured Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

The Insurer will pay Reasonable Charges for escort services if the Insured Person is a minor or if the Insured Person is disabled during a trip and an escort is recommended in writing by the attending Physician and approved by the Insurer.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

If following stabilization, when medically necessary and subject to the Administrator's prior approval, the Insurer will pay for a medically supervised return to the Insured Person's permanent residence or, if appropriate, to a health care facility nearer to their permanent residence or for one-way economy airfare to the Insured Person's point of origin, if necessary.

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

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

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

#### **[Bedside Visit Benefit**

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than <7 - 14> days, is likely to be hospitalized for more than <7 - 14> days or is in critical condition, ], [while {traveling / living} outside of his/her home country [{for an uninterrupted period of less than <90-365> days / while traveling more than 100 miles from their place of residence [on an overnight trip]}], the Insurer will {pay / purchase} [up to the maximum benefit as listed in Table 1 of the Schedule of Benefits] for the cost of one economy round trip air fare ticket to[, and the [meals] [and][hotel

accommodations] in,] the place of the Hospital Confinement for one person designated by the Insured Person. Payment for [meals,] ground transportation and other incidentals are the responsibility of the family member or friend.

[With respect to any one trip, this benefit is payable only once for that trip, regardless of the number of Insured Persons on that trip.] The determination of whether the Covered Member will be hospitalized for more than <7 – 14 days> or is in critical condition shall be made by the Administrator after consultation with the attending physician. No more than one (1) visit may be made during any 12 month period. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

[This benefit is available only to Insured Persons who are traveling outside of their Home Country while covered under this Plan.]

The benefit for all Bedside Visits is listed in the Overview Matrix.]

## VI. Exclusions and Limitations: What the Plan does not pay for

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### Excluded Services

The Plan does not provide any benefits for:

- [<1.> Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Plan.]
- [<2.> Services **not specifically listed** in this Plan as Covered Services.]
- [<3.> Services or supplies that are **not Medically Necessary** as defined by the Insurer.]
- [<4.> Services or supplies that the Insurer considers to be **Experimental or Investigative**.]
- [<5.> Services received **before the Effective Date** of coverage or during an inpatient stay that began before that Effective Date of Coverage.]
- [<6.> Services received **after coverage ends** unless an extension of benefits applies as specifically stated under Extension of Benefits in the 'Who is Eligible for Coverage' section of this Plan.]
- [<7.> Services for which the Insured Person has **no legal obligation to pay** or for which no charge would be made if he/she did not have a health policy or insurance coverage.]
- [<8.> Services for any condition for **which benefits are recovered or can be recovered**, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
- [<9.> Treatment or medical services required **while traveling against the advice of a Physician**, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.]
- [<10.> Services related to **pregnancy or maternity** care other than for complications of pregnancy that may arise during a Trip Coverage Period.
- [<11.> Conditions caused by or contributed by (a) **[an act of war;]** (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) An Insured Person participating in the **military service** of any country; (d) An Insured Person participating in an **insurrection, rebellion, or riot**; (e) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a **felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation**; (f) An Insured Person, age 19 or older, being under the **influence of alcohol or intoxicants or of illegal narcotics** or non-prescribed controlled substances unless administered on the advice of a Physician.]
- [<12.> Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is **related to the Insured Person** by blood, marriage or adoption, or the Insured Person's employer.]
- [<13.> Inpatient or outpatient services of a **private duty nurse**.]
- [<14.> Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.]
- [<15.> Inpatient room and board charges in connection with a Hospital stay primarily for **diagnostic tests** which could have been performed safely on an outpatient basis.]
- [<16.> Treatment of **Mental, Emotional or Functional Nervous Conditions or Disorders**.]
- [<17.> Treatment of **Drug, alcohol, or other substance addiction or abuse**.]
- [<18.> **Dental services**, dentures, bridges, crowns, caps or other dental prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically stated under **[Dental Care and/or] Dental Care for Accidental Injury]** in the Benefits section of this Plan.]
- [<19.> Dental and orthodontic services for Temporomandibular Joint Dysfunction (**TMJ**).]
- [<20.> **Orthodontic Services**, braces and other orthodontic appliances[ except as specifically stated under Orthodontic Dental Care].
- [<21.> **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.]
- [<22.> **Hearing aids**.]
- [<23.> Routine **hearing tests**.]
- [<24.> **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.]
- [<25.> An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).]
- [<26.> Outpatient **speech therapy**.]
- [<27.> Any **Drugs**, medications, or other substances [dispensed or administered in any outpatient setting] except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.
- [<28.> Any intentionally **self-inflicted Injury or Illness**. [This exclusion does not apply [to the Medical Evacuation Benefit,] [to the Repatriation of Remains Benefit] [and] [to the Bedside Visit Benefit.]]
- [<29.> **Cosmetic surgery** or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or to Medically Necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.]
- [<30.> Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**.]
- [<31.> Treatment of **sexual dysfunction** or inadequacy.]
- [<32.> All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization
- [<33.> All **contraceptive** services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures.]

- [<34.> **Cryopreservation** of sperm or eggs.]
- [<35.> **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.]
- [<36.> Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method of treatment.]
- [<37.> **Routine physical exams** or tests that do not directly treat an actual illness, injury or condition, including those required by employment or government authority.]
- [<38.> Charges by a provider for **telephone consultations.**]
- [<39.> Items which are furnished primarily for the Eligible Participant's **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc..)]
- [<40.> **Educational services** except as specifically provided or arranged by the Insurer.]
- [<41.> **Nutritional counseling** or food supplements.]
- [<42.> **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Plan. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings.]
- [<43.> **Physical and/or Occupational Therapy/Medicine**, except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.]
- [<44.> All **infusion therapy, radiation therapy and hemodialysis treatment** together with any associated supplies, Drugs or professional services are excluded.]
- [<45.> **Growth Hormone Treatment.**]
- [<46.> Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized illness, injury or symptoms involving the feet.]
- [<47.> **Charges for which the Insurer are unable to determine the Insurer's liability** because the Eligible Participant or an Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize the Insurer to receive all the medical records and information the Insurer requested; or (b) provide the Insurer with information the Insurer requested regarding the circumstances of the claim or other insurance coverage.]
- [<48.> Charges for the services of a **standby Physician.**]
- [<49.> Charges for **animal to human organ transplants.**]
- [<50.> Under the medical treatment benefits, for loss due to or arising from a motor vehicle Accident if the Insured Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.]
- [<51.> [Loss arising from
  - [a. participating in any intercollegiate/interscholastic or professional sport, contest or competition;]
  - [b. participating in any intramural sport competition, contest or competition;]
  - [c. participating in any club sport competition, contest or competition;]
  - [d. participating in any professional sport, contest or competition;]
  - [e. traveling to or from such sport, contest or competition as a participant;]
  - [f. while participating in any practice or condition program for such sport, contest or competition;]
  - [g. Racing or speed contests;]
  - [h. [skin/scuba diving], [sky diving], [mountaineering (where ropes are customarily used)], [ultra light aircraft], [parasailing], [sail planning], [hang gliding], [bungee jumping], [travel in or on ATV's (all terrain or similar type vehicles)].]
- [<52.> Medical treatment, services, supplies, or Confinement in a Hospital owned or operated by a **national government** or its agencies. (This exclusion does not apply to charges the law requires the Insured Person to pay.)]
- [<53.> Claims arising from loss due to riding in any **aircraft** except one licensed for the transportation of passengers.]
- [<54.> [Claims arising from [participation in interscholastic or professional and/or non-professional club **sports or sports event** or] participation in mountaineering, motor racing, speed contests, skydiving, hang gliding, parachuting, spelunking, heliskiing, extreme skiing or bungee cord jumping.]
- [<55.> Treatment for or arising from **sexually transmittable diseases**. (This exclusion does not apply to HIV, AIDS, ARC or any derivative or variation.)]
- [<56.> [Under the **Accidental Death and Dismemberment provision**, for loss of life or dismemberment for or arising from an Accident {in the Insured Person's Home Country / in the U.S. / less than <100 – 1,000> miles from the Insured Person's Home}; for loss of life or dismemberment due to a Sickness, disease or infection.]
- [<57.> [Under the **Accidental Death and Dismemberment provision**, for loss of life or dismemberment resulting directly or indirectly from the discharge, explosion, or use of any device, weapon, material employing or involving fission, nuclear fusion, or radioactive force, or chemical, biological radiological or similar agents, whether in time of peace or war, and regardless of any other causes or events contribution concurrently or in any other sequence there to.]
- [<58.> [Under the **Accidental Death and Dismemberment provision**, for loss of life or dismemberment caused by or contributed by (a) [an act of war;] (b) An Insured Person participating in the military service of any country; (c) An Insured Person participating in an insurrection, rebellion, or riot; (d) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation;]
- [<59.> [Under the **Repatriation of Remains Benefit and the Medical Evacuation Benefit provision**, for repatriation of remains or medical evacuation of the Covered Accident {in the Insured Person's Home Country / in the U.S. / less than <100 – 1,000> miles from the Insured Person's Home}without the prior approval of the Administrator.]

[<60.> [Treatment of **Congenital Conditions.**]

**[Pre-existing Conditions**

{Benefits are not available for any services received on or within <0 – 6> months after the **Trip Coverage Start Date** of an Insured Person, if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to a Newborn that is enrolled within 31 days of birth or a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption.}

**NOTE: Creditable Coverage does not apply to this blanket travel Plan.**

{This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit [or to US Citizens traveling outside of the United States.]}

## **[VII. Prescription Drug Benefits**

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**Pharmacy** means a licensed retail pharmacy.

**Prescription** means a written order issued by a Physician.

### **What Is Covered**

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

### **Conditions of Service**

The Drug or medicine must be:

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

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

The Prescription must not exceed a 30-day supply.

### **Prescription Drug Exclusions and Limitations**

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

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

**Exception to Exclusions and Limitations for certain Cancer Drug treatment**

An exception is made to the Exclusions and Limitations for certain cancer drug treatment. If a drug has not yet received formal FDA approval for use in treating a specific cancer, but is recognized for treatment of that specific cancer in one of the following references, it will be covered; AMA Drug Evaluations, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Drug Information, or recommended by review article or editorial comment in a major peer-reviewed professional journal. In addition, a service will not be considered experimental or investigational if it is part of a clinic trial program.]

## VIII. General Provisions

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### Third Party Liability

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

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

### Benefits for Medicare Eligible Insured Persons

Insured Persons eligible for Medicare receive the full benefits of this Plan, except for those Insured Persons listed below:

1. Insured Persons who are receiving treatment for end-stage renal disease following the first 30 months such Insured Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
2. Insured Persons who are entitled to Medicare benefits as disabled persons, unless the Insured Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more employees (subject to COBRA legislation).
3. Insured Persons who are entitled to Medicare for any other reason, unless the Insured Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more employees (subject to COBRA legislation).

In cases where exceptions 1, 2 or 3 apply, the Insurer will determine the Insurer's payment and then subtract the amount of benefits available from Medicare. The Insurer will pay the amount that remains after subtracting Medicare's payment. Please note, the Insurer will not pay any benefit when Medicare's payment is equal to or more than the amount which we would have paid in the absence of Medicare.

**For example:** Assume exception 1, 2 or 3 applies to the Insured Person, and he/she is billed for \$100 of Covered Expense. And assume in the absence of Medicare, the Insurer would have paid \$80. If Medicare pays \$50, the Insurer would subtract that amount from the \$80 and pay \$30. However, if in this example, Medicare's payment is \$80 or more, the Insurer will not pay a benefit.

### [Alternate Cost Containment Provision

If it will result in less expensive treatment, the Insurer may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. It must be mutually agreed to by the Insurer, the Insured Person, and the Insured Person's Physician, Provider, or other healthcare practitioner. The Insurer's offering an alternate treatment plan in a particular case in no way commits the Insurer to do so in another case, nor does it prevent the Insurer from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Insured Person.]

### Terms of the Insured Participant's Plan

1. **Entire Contract and Changes:** The entire contract between the Group and the Insurer is as stated in the Policy and the entire contract between the Insured Participant and the Insurer is as stated in the Certificate of Coverage including the endorsements, application, if any, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of the Insurer's officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.
2. **Payment of Premiums:** Premiums are payable in advance. Premiums must be paid monthly including any contributions the Insured Participant must make. The Insurer may change the premium rates from time to time. The Insurer must give the Group written notice of any premium rate change at least 30 days prior to the change. The Insurer may not increase premiums without first providing written notification to the Group at least 30 days prior to the date the increase is to take effect, with the exception of retroactive premium rate increases related to fraud or the intentional misrepresentation of a material fact.
3. **Grace Period:** There is a Grace Period of 31 days allowed for the payment of each premium after the first premium.
4. **Representations:** All statements made by the Insured Participant or the Group shall be considered representations and not warranties. The Insurer must provide the Insured Participant or the Group with a copy of any statements used to contest coverage.
5. **Time Limit on Certain Defenses/Misstatements on the Application:** After two years from the Effective Date of the Policy, the Insurer will not contest the validity of the Policy. After two years from the Insured Participant's Effective Date of Coverage, no misstatements on the Eligible Participant's application may be used to:
  - a. void this coverage, or
  - b. deny any claim for loss incurred or disability that starts after the 2 year period.The above does not apply to fraudulent misstatements.

6. **Legal Actions:** The Insured Person cannot file a lawsuit before 60 days after the Insurer has been given written proof of loss. No action can be brought after 3 years from the time that proof is required to be given.
7. **Conformity with State Statutes:** If any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Policyholder resides, it is amended to conform to the minimum requirements of those statutes.
8. **Provision in Event of Partial Invalidity:** If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.
9. **The Claims Process**  
**Notice of Claim:** Within 20 days after an Insured Person receives Covered Services, or as soon as reasonably possible, he/she or someone on his/her behalf, must notify the Insurer in writing of the claim.

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

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

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

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

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

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

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

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

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

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

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

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

10. **Misstatement of Age:** If the age of an Insured Person has been misstated, an adjustment of premiums shall be made based on the Insured Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.
11. **Right to Recovery:** If the Insurer makes benefit payments in excess of the benefits payable under the provisions of the Plan, the Insurer has the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.
12. **Plan Administrator – COBRA and ERISA.** In no event will the Insurer be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than the Insurer, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Eligible Participant's agent.
13. **Waiver of Rights:** Failure by the Insurer to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.
14. **Physical Exam and Autopsy:** The Insurer has the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Insured Participant will not have to pay for it.
15. **Required Information:** The Group will furnish the Insurer all information necessary to calculate the Premium and all other information that the Insurer may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. The Insurer has the right to examine any records of the Group, any person, company or organization which may effect the Premiums and benefits of the Plan.

The Insurer's right to examine any records exists:

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

#### 16. **Coordination of Benefits (COB) Provision:**

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

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

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

#### **Definitions**

- A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
  1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
  2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **The order of benefit determination rules** determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.  
When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
- D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.  
The following are examples of expenses that are not Allowable expenses:
1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
  2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
  3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
  4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
  5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. **Closed panel plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

**Order of Benefit Determination Rules.** When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B.
  1. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
  2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
  1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the

order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
  - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
    - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
  - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
    - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
    - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The Plan covering the Custodial parent;
      - The Plan covering the spouse of the Custodial parent;
      - The Plan covering the non-custodial parent; and then
      - The Plan covering the spouse of the non-custodial parent.
  - c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

**Effect on the Benefits of This Plan.** When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

**Right To Receive And Release Needed Information.** Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The Insurer may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The Insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Insurer any facts it needs to apply those rules and determine benefits payable.

**Facility of Payment.** A payment made under another Plan may include an amount that should have been paid under This plan. If it does, the Insurer may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The Insurer 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 the reasonable cash value of the benefits provided in the form of services.

**Right of Recovery.** If the amount of the payments made by the Insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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

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

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

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

The Insured Person has the right to appeal any denial of a claim for benefits by submitting a written request for reconsideration with the Insurer. Requests for reconsideration must be filed within 60 days after receipt of the written notification of denial. When the Insurer receives the Insured Person's written request, the Insurer will review the claim and arrive at a determination.

If the matter is still not resolved to the Insured Person's satisfaction, he/she may request a second review of the claim by sending the Insurer a written request for a second reconsideration. This written request must be filed within 60 days of the Eligible Participant's receipt of the Insurer's written notification of the result of the first review. If the issue involves a dispute over the coverage of medical services, or the extent of that coverage, the second review will be completed by physician consultants who did not take part in the initial reconsideration. The Insured Person will be informed, in writing, of the Insurer's final decision.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Eligible Participant or the Group because the Eligible Participant, the Group, or any person acting on the Eligible Participant's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

The Insurer will meet any Notice requirements by mailing the Notice to the Group at the billing address listed on our records. The Group will meet any Notice requirements by mailing the Notice to:

4 Ever Life Insurance Company  
c/o [Authorized Administrator  
Address  
City, State zip  
Telephone No. 1-8xx-xxx-xxxx]

### **Dispute Resolution**

All complaints or disputes relating to coverage under this Plan must be resolved in accordance with the Insurer's grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by the Insurer that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer proposes to resolve the grievance.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Insured Person or the Group because the Insured Person's, the Group's, or any person's action on the Insured Person's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

# 4 Ever Life Insurance Company

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

Administrative Office: [c/o Authorized Administrator, Address, City, State Zip)

## Endorsement to Policy/Certificate

State of Arkansas

This Endorsement is made part of the policy/certificate to which it is attached as of the effective date of such policy/certificate.

By attachment of this Endorsement, it is understood and agreed that the insurance under the policy/certificate is amended, with respect to Covered Persons residing in the state of Arkansas, as follows:

1. The following notice is added:

### CONSUMER NOTICE

If a Covered Person has any questions or concerns about this coverage, the Covered Person should contact the Insurer, or their designated administrator, at the address or phone number shown on their ID card. If the Insurer is not able to provide a satisfactory resolution to the inquiry, the Covered Person may contact the:

Arkansas Department of Insurance  
Consumer Services  
1200 W. Third Street  
Little Rock, AR 72201-1904  
800-371-2640  
501-371-2640

2. Section VI, Exclusions and Limitations: What the Plan does not pay for, Exclusion 11 is hereby deleted in its entirety and replaced with the following:  

[<11.> Conditions caused by or contributed by (a) **an act of war**; (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) An Insured Person participating in the **military service** of any country; (d) An Insured Person participating in an **insurrection, rebellion, or riot**; (e) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a **felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation**; (f) An Insured Person, age 19 or older, being under the **influence of alcohol or intoxicants or of illegal narcotics** or non-prescribed controlled substances unless administered on the advice of a Physician.]
3. Section II, Who is eligible for coverage?, under Eligible Dependents, if included, item 5.a. is deleted in its entirety and replaced with the following:
  - a. Newborn Children: Coverage will be automatic for the first 90 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 90 days, the Newborn child must be enrolled within 90 days of birth.
4. Section II, Who is eligible for coverage?, under Eligible Dependents, if included, item 5.b. is deleted in its entirety and replaced with the following:
  - b. Adopted Children: An Insured Participant's adopted child is automatically covered for Illness or Injury from the date of the filing of a petition for adoption if the Insured Participant applies for coverage within 60 days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage if filed within 60 days after the birth of the child. To continue coverage beyond 60 days, an

Insured Participant must enroll the adopted child within 60 days either from the date of placement or the final decree of adoption. Coverage of an adopted child shall terminate upon dismissal or denial of a petition for adoption.

5. Section VI, Exclusions and Limitations: What the Plan does not pay for, the Pre-existing Conditions provision is deleted in its entirety and replaced with the following:

**[Pre-existing Conditions**

{Benefits are not available for any services received on or within <0 – 6> months after the **Trip Coverage Start Date** of an Insured Person, if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to a Newborn that is enrolled within 90 days of birth or a newly adopted child that is enrolled within 60 days from either the date of placement of the child in the home, or the date of the final decree of adoption.]

6. Section II, Who is eligible for coverage?, the Extension of Benefits provision is deleted in its entirety and replaced with the following:

No benefits are payable for medical treatment benefits if a Policy Holder's insurance terminates. However, if the Insured Person is in a Hospital on the date that the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date the confinement ends, the Trip Coverage Period ends, or benefits under the Policy are exhausted.

7. Section VIII, General Provisions, the definition of Plan within the Coordination of Benefits (COB) provision item A is deleted and replaced with the following:

**Plan** means any of these which provides benefits or services for, or because of, medical care or treatment:

- (1) all group or blanket disability policies or group subscriber contracts of hospital and medical service corporations, union welfare plans, employer or employee benefit organization or workmen's compensation insurance as well as franchise insurance.
- (2) medical and hospital benefits under either group or individual automobile "No-Fault" contracts to the extent provided above but, as to the traditional automobile tort liability contracts, only the medical benefits written on a group or group-type basis.

"Plan" does not include the following: individually underwritten and issued hospital, medical expense, or dread disease policies, including cancer insurance; group hospital indemnity benefits (written on a non-expense incurred basis) of \$30 per day or less; student accident type coverages, written on either an individual, group, blanket or franchise basis;

8. Section VIII, General Provisions, the definition of Allowable Expenses within the Coordination of Benefits (COB) provision item D is amended to add the following:

**Allowable Expense** means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Covered Person for whom claim is made.

9. Section II, Who is eligible for coverage?, the definition of Eligible Dependent, item 3, is deleted and replaced with the following:

3. own or spouse's own unmarried child, of any age, enrolled prior to age <19 – 26>, who is incapable of self support due to continuing mental retardation or physical disability and who is chiefly dependent on the Eligible Participant. The Insurer requires written proof from a Physician of such disability and dependency. Continued proof of such disability and dependency must be furnished annually following the child's <19<sup>th</sup> – 26<sup>th</sup>> birthday;

**THIS ENDORSEMENT IS SUBJECT TO ALL PROVISIONS OF THE POLICY/CERTIFICATE NOT INCONSISTENT HEREWITH.**

  
SECRETARY

  
PRESIDENT

**4 EVER LIFE INSURANCE COMPANY**  
**SUPPLEMENTAL BLANKET TRAVEL PLAN**  
**PARTICIPATING ORGANIZATION GROUP APPLICATION/REQUEST TO PARTICIPATE**

Administered by:  
[Authorized Administrator  
Address  
City, State zip]

Policy No. \_\_\_\_\_

Legal Company Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

SIC Code \_\_\_\_\_ Contact for Administration & Eligibility \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Contact for Billing \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ # <Employees/Members> : \_\_\_\_\_ # Eligible \_\_\_\_\_ # of <Employees/Members> with Dependents \_\_\_\_\_

Participating Organization's Requested Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

We elect to offer the following coverages to our [Employees][Members] :

[Product Name] Describe: \_\_\_\_\_

The Participating Organization agrees to participate in the [HTH International Group Insurance Trust]. The Participating Organization acknowledges that as a Participating Organization, the Participating Organization is establishing this group insurance plan. Neither 4 Ever Life Insurance Company nor the policyholder/trustee is acting as a "sponsor", as defined in ERISA. Participating Organization agrees that any compliance with ERISA that is applicable to the Participating Organization is the responsibility of the Participating Organization.

The insurance coverage requested and requested effective date must be approved by **[Authorized Administrator]** under its current rules and practices, including Evidence of Insurability and Pre-Existing Condition provisions. All materials describing this coverage must be approved in writing by **[Authorized Administrator]** prior to distribution. Note: Premium rates quoted were based on the data submitted to **[Authorized Administrator]**. Final premium rates may be determined on the basis of the actual composition of the group of persons who become insured. I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **[Authorized Administrator]** approval of the coverage requested.

**Applicant** hereby accepts the above quote and requests coverage designated by **[Authorized Administrator]** and appoints **[Authorized Administrator]** as its representative for the placement of this supplemental blanket travel plan.

## FRAUD NOTICES

**Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signed by Participating Organization:

\_\_\_\_\_

Name

\_\_\_\_\_

Title

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

4 Ever Life Insurance Company Representative:

\_\_\_\_\_

Name

\_\_\_\_\_

Title

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please mail completed Group Application/Request to Participate and accompanying Enrollment Forms and Initial Payment to:

**4 Ever Life Insurance Company**  
c/o [Authorized Administrator, Address  
City, State, Zip  
Questions? Call: 1-8xx-xxx-xxxx]

SERFF Tracking Number: MCHX-G127611042 State: Arkansas  
 Filing Company: 4 Ever Life Insurance Company State Tracking Number: 49697  
 Company Tracking Number: FORM 55.203  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Form 55.202 Business Traveler Blanket Insurance -  
 Project Name/Number: Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company /Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachments:</b> AR Readability Cert-4Ever.PDF AR Cert of Compliance with Rule 19.PDF AR Certificate of Compliance 23-79-138 and R&R 49.PDF	Approved-Closed	09/26/2011
<b>Satisfied - Item:</b> Application <b>Comments:</b> Please see form schedule.	Approved-Closed	09/26/2011
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	09/26/2011
<b>Satisfied - Item:</b> Submission Letter <b>Comments:</b> <b>Attachment:</b> AR 4 EVER LIFE BT OUT-OF-STATE FILING LTR 8_2011.PDF	Approved-Closed	09/26/2011

Item Status: Status Date:

SERFF Tracking Number: MCHX-G127611042 State: Arkansas  
Filing Company: 4 Ever Life Insurance Company State Tracking Number: 49697  
Company Tracking Number: FORM 55.203  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Form 55.202 Business Traveler Blanket Insurance -  
Project Name/Number: Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company /Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company

**Satisfied - Item:** Dual Filing Letter Approved-Closed 09/26/2011

**Comments:**

**Attachment:**

AR DUAL BT OUT-OF-STATE FILING LTR 8\_2011.PDF

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Authorization Letter Approved-Closed 09/26/2011

**Comments:**

**Attachment:**

4 Ever Life 2011 MCR Authorization Letter.PDF

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** 09.21.11 Resubmission Letter Approved-Closed 09/26/2011

**Comments:**

**Attachment:**

AR 4 Ever Life BT Objection Response 9\_2011.PDF

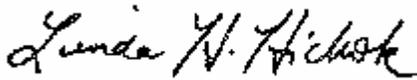
**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** 4 Ever Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
Form 55.203(DE)	40
Form 55.205(AR)	40
Form 55.201	40

Signed: \_\_\_\_\_



Name: Linda H. Hickok

Title: Assistant Vice President

Date: 09/01/2011

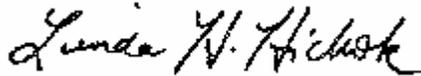
## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: 4 Ever Life Insurance Company

Form 55.203(DE), Form 55.205(AR), Form 55.201

Form Number(s):

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



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Signature of Company Officer

Linda H. Hickok

---

Name

Assistant Vice President

---

Title

09/01/2011

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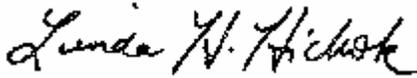
Date

**CERTIFICATE OF COMPLIANCE**

Insurer: 4 Ever Life Insurance Company

Form Numbers: Form 55.203(DE), Form 55.205(AR), Form 55.201

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



---

Signature of Company Officer

Linda H. Hickok

---

Name

Assistant Vice President

---

Title

09/01/2011

---

Date

.....  
**McHugh Consulting Resources, Inc.**

September 1, 2011

**SENT VIA SERFF**

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

Re: **4 Ever Life Insurance Company**  
**NAIC No.: 80985**  
**FEIN: 36-2149353**

**Business Traveler Program – OUT OF STATE GROUP FILING**

Form 55.203(DE) Supplemental Blanket Travel Plan Certificate  
Form 55.205(AR) Endorsement to Policy/Certificate  
Form 55.201 Supplemental Blanket Travel Plan Participating Organization  
Application/Request to Participate

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the above-referenced forms on behalf of 4 Ever Life Insurance Company. We have provided a letter of authorization for your files.

We are submitting the above captioned forms for your review and approval. These forms are new and not intended to replace any other forms currently in use.

This program provides supplemental blanket travel coverage while a person is temporarily traveling for business internationally either to or from the United States. The plan is supplemental to health insurance under a group plan that does not provide coverage while an insured person is traveling outside of his or her home country.

The policy may be issued to a trust established in Delaware known as the HTH International Group Insurance Trust (Christiana Bank & Trust Company as Trustee) where subscribers to the trust will be employer groups that elect to participate in the trust in accordance with T. 18 §§3502 and 3509. Policy Form 55.202 was approved by Delaware on August 9, 2011. This program will be marketed through agent/broker solicitation and direct solicitation to employer groups.

Endorsement Form 55.205(AR) will be used to bring the policy/certificate into compliance with your state requirements. The appropriate language contained in the endorsement will be used as an attachment to the certificate or it may be included in the body of the certificate, where appropriate.

Supplemental Blanket Travel Plan Participating Organization Application/Request to Participate Form 55.201 will be completed by employer groups participating in the trust.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific college, school or university's request. Variable data will never exclude or limit provisions required by your state.

Printing of all forms is subject to changes in page numbers, margins, positioning and format. Printing standards will never be less than required under your law. Electronic use of this form may result in changes or variations in margins, formatting and pagination. However, the text will not be less than ten-point type and the form will meet the readability standards required under your law.

4 Ever Life Insurance Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

Enclosed please find any required certifications and/or transmittal forms. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

A handwritten signature in cursive script that reads "Jeanne Heider".

Jeanne Heider  
Consultant

*Enclosures*

.....

# McHugh Consulting Resources, Inc.

September 1, 2011

**SENT VIA SERFF**

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

RE; **4 Ever Life Insurance Company**  
NAIC No.: 80985  
FEIN: 36-2149353

**BCS Insurance Company**  
NAIC No.: 38245  
FEIN: 36-6033921

**BUSINESS TRAVELER PROGRAM – OUT OF STATE GROUP FILING**

Dear Commissioner Bradford:

Enclosed are identical filings of a new supplemental blanket travel product being submitted for two insurers under the same parent company: 4 Ever Life Insurance Company and BCS Insurance Company. Certificate Form 55.203(DE), *et al* is for 4 Ever Life Insurance Company SERFF Filing No. MCHX-G127611042, and Certificate Form 55.103(DE), *et al* is for BCS Insurance Company SERFF Filing No. MCHX-G127611038.

Each company submission has been prepared separately and in accordance with your state's filing guidelines. These new certificate forms, Form 55.203(DE) and Form 55.103(DE), are identical except for the form numbers, respective company information and "Services Inside the U.S., Puerto Rico, and the U.S. Virgin Island" provision which appears on page 2 of certificate form 55.203(DE) only. Therefore, we would respectfully request that these forms be reviewed together.

Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding these filings.

Sincerely,



Jeanne Heider  
Consultant

Attachments



Insurance Group

Linda H. Hickok,  
Assistant Vice President,  
Compliance

BCS Life Insurance Company  
BCS Insurance Company  
2 Mid America Plaza, Suite 200  
Oakbrook Terrace, Illinois 60181  
T 630.472.7726 F 630.472.7822  
lhickok@besigroup.com

Date: June 17, 2011  
To: State Insurance Department  
From: Linda H. Hickok, Vice President, Compliance  
4 Ever Life Insurance Company  
Subject: Filing Authorization for McHugh Consulting Resources, Inc.

This is to inform you that McHugh Consulting Resources, Inc., of 2005 S. Easton Road, Suite 207, Doylestown, Pennsylvania 18901, has been retained to act on our behalf as indicated herein.

McHugh Consulting Resources, Inc. is hereby empowered to act on behalf of 4 Ever Life Insurance Company in any governmental jurisdiction of the United States in matters regarding the filing of insurance products, forms, rates, advertising materials, and any other materials incidental to the acceptance of such filings.

Your cooperation in working with McHugh Consulting Resources, Inc. is greatly appreciated. This authorization shall be effective until such time as we notify you otherwise.

Signature: Linda H. Hickok

.....

# McHugh Consulting Resources, Inc.

September 21, 2011

**SENT VIA SERFF**

Ms. Rosalind Minor  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

Re: **4 Ever Life Insurance Company**  
**NAIC No.: 80985**  
**FEIN: 36-2149353**

**Business Traveler Program – OUT OF STATE GROUP FILING**

Form 55.203 (DE) Supplemental Blanket Travel Plan Certificate  
Form 55.205 (AR) Endorsement to Policy/Certificate  
Form 55.201 Supplemental Blanket Travel Plan Participating Organization  
Application/Request to Participate

**SERFF Tracking Number: MCHX – G127611042**  
**Response to Objection Letter dated September 9, 2011**

Dear Ms. Minor:

McHugh Consulting Resources is in receipt of your objection letter dated September 9, 2011 regarding the captioned filing. We have responded to your concern as follows:

**Objection 1**

**Your comments:** Under Eligible Dependent, handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-102(8) and Bulletin 14-81.

**Response:** We have revised item 3 under the definition of Eligible Dependent, Section II, Who is eligible for coverage?, in AR Endorsement, Form 55.205(AR). A revised AR Endorsement is attached for your review.

Ms. Rosalind Minor  
4 Ever Life Insurance Company  
Page 2

Thank you for your continued attention to this filing. Please do not hesitate to contact the undersigned at 215.230.7960 if there are any questions that we can answer regarding this filing.

Sincerely,

A handwritten signature in cursive script that reads "Jeanne Heider".

Jeanne Heider  
Consultant  
McHugh Consulting Resources, Inc.  
215-230-7960  
[mcr@mchughconsulting.com](mailto:mcr@mchughconsulting.com)

SERFF Tracking Number: MCHX-G127611042 State: Arkansas  
 Filing Company: 4 Ever Life Insurance Company State Tracking Number: 49697  
 Company Tracking Number: FORM 55.203  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Form 55.202 Business Traveler Blanket Insurance -  
 Project Name/Number: Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company /Form 55.202 Business Traveler Blanket Insurance - 4 Ever Life Insurance Company

## 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)
09/01/2011	Form	Endorsement to Policy/Certificate	09/21/2011	AR 4EL Business Traveler Endorsement CLEAN 8_2011.PDF (Superseded)

# 4 Ever Life Insurance Company

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

Administrative Office: [c/o Authorized Administrator, Address, City, State Zip)

## Endorsement to Policy/Certificate State of Arkansas

This Endorsement is made part of the policy/certificate to which it is attached as of the effective date of such policy/certificate.

By attachment of this Endorsement, it is understood and agreed that the insurance under the policy/certificate is amended, with respect to Covered Persons residing in the state of Arkansas, as follows:

1. The following notice is added:

### CONSUMER NOTICE

If a Covered Person has any questions or concerns about this coverage, the Covered Person should contact the Insurer, or their designated administrator, at the address or phone number shown on their ID card. If the Insurer is not able to provide a satisfactory resolution to the inquiry, the Covered Person may contact the:

Arkansas Department of Insurance  
Consumer Services  
1200 W. Third Street  
Little Rock, AR 72201-1904  
800-371-2640  
501-371-2640

2. Section VI, Exclusions and Limitations: What the Plan does not pay for, Exclusion 11 is hereby deleted in its entirety and replaced with the following:

[<11.> Conditions caused by or contributed by (a) **an act of war**; (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) An Insured Person participating in the **military service** of any country; (d) An Insured Person participating in an **insurrection, rebellion, or riot**; (e) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a **felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation**; (f) An Insured Person, age 19 or older, being under the **influence of alcohol or intoxicants or of illegal narcotics** or non-prescribed controlled substances unless administered on the advice of a Physician.]

3. Section II, Who is eligible for coverage?, under Eligible Dependents, if included, item 5.a. is deleted in its entirety and replaced with the following:

- a. Newborn Children: Coverage will be automatic for the first 90 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 90 days, the Newborn child must be enrolled within 90 days of birth.

4. Section II, Who is eligible for coverage?, under Eligible Dependents, if included, item 5.b. is deleted in its entirety and replaced with the following:

- b. Adopted Children: An Insured Participant's adopted child is automatically covered for Illness or Injury from the date of the filing of a petition for adoption if the Insured Participant applies for coverage within 60 days after the filing of the

petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage if filed within 60 days after the birth of the child. To continue coverage beyond 60 days, an Insured Participant must enroll the adopted child within 60 days either from the date of placement or the final decree of adoption. Coverage of an adopted child shall terminate upon dismissal or denial of a petition for adoption.

5. Section VI, Exclusions and Limitations: What the Plan does not pay for, the Pre-existing Conditions provision is deleted in its entirety and replaced with the following:

**[Pre-existing Conditions**

{Benefits are not available for any services received on or within <0 – 6> months after the **Trip Coverage Start Date** of an Insured Person, if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to a Newborn that is enrolled within 90 days of birth or a newly adopted child that is enrolled within 60 days from either the date of placement of the child in the home, or the date of the final decree of adoption.]

6. Section II, Who is eligible for coverage?, the Extension of Benefits provision is deleted in its entirety and replaced with the following:

No benefits are payable for medical treatment benefits if a Policy Holder's insurance terminates. However, if the Insured Person is in a Hospital on the date that the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date the confinement ends, the Trip Coverage Period ends, or benefits under the Policy are exhausted.

7. Section VIII, General Provisions, the definition of Plan within the Coordination of Benefits (COB) provision item A is deleted and replaced with the following:

**Plan** means any of these which provides benefits or services for, or because of, medical care or treatment:

- (1) all group or blanket disability policies or group subscriber contracts of hospital and medical service corporations, union welfare plans, employer or employee benefit organization or workmen's compensation insurance as well as franchise insurance.
- (2) medical and hospital benefits under either group or individual automobile "No-Fault" contracts to the extent provided above but, as to the traditional automobile tort liability contracts, only the medical benefits written on a group or group-type basis.

"Plan" does not include the following: individually underwritten and issued hospital, medical expense, or dread disease policies, including cancer insurance; group hospital indemnity benefits (written on a non-expense incurred basis) of \$30 per day or less; student accident type coverages, written on either an individual, group, blanket or franchise basis;

8. Section VIII, General Provisions, the definition of Allowable Expenses within the Coordination of Benefits (COB) provision item D is amended to add the following:

**Allowable Expense** means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Covered Person for whom claim is made.

**THIS ENDORSEMENT IS SUBJECT TO ALL PROVISIONS OF THE POLICY/CERTIFICATE NOT INCONSISTENT HEREWITH.**

  
SECRETARY

  
PRESIDENT