GroupSecure
Description of Coverage

This Description of Coverage is a summary of the provisions contained in Master Policy No. 081922-28A. For a complete copy of the Master Policy, please contact HCC Medical Insurance Services.

MEMBER ELIGIBILITY, CERTIFICATE EFFECTIVE AND TERMINATION DATE, REGULAR ENROLLMENT, TERMINATION OF COVERAGE, SPECIAL ENROLLMENT

ELIGIBILITY

In order to be an Eligible Employee, the following conditions must be met:

A. The employee must be an Active Full-time (as defined herein) employee of the Participating Organization; and
B. If the employee is in the United States on the Effective Date of this Certificate or on the Effective Date of Coverage hereunder (if later than the Effective Date of this Certificate), the employee must plan to depart the United States within thirty (30) days, beginning on the Effective Date of this Certificate or beginning on the Effective Date of Coverage hereunder (if later than the Effective Date of this Certificate).

CERTIFICATE EFFECTIVE AND TERMINATION DATE

Insurance under any Certificate shall become Effective on the date specified by Underwriters, and indicated on the Declaration of the Certificate. Insurance under any Certificate can be terminated by the Participating Organization by giving at least thirty (30) days advance written notice to Underwriters. Furthermore, insurance under any Certificate terminates on the earliest of the following dates:

A. The date the Participating Organization no longer meets the requirements set forth in Article 2 herein; or
B. The end of the period for which Premium has been paid; or
C. Ninety (90) days following receipt of written notice from Underwriters, in the event the Master Policy is terminated in accordance with its terms; or
D. The date that all covered employees of the Participating Organization are located in the United States; or
E. Twelve (12) months following the Effective Date indicated on this Certificate unless the Participating Organization has applied for renewal of this Certificate as offered by Underwriters and on forms acceptable to Underwriters.

REGULAR ENROLLMENT OF ELIGIBLE EMPLOYEE

Only Eligible Employees may enroll for coverage. In order to enroll, the employee must:

A. If the employee is an Eligible Employee on the day immediately preceding the Effective Date of this Certificate, the employee must submit to Underwriters a completed Enrollment Form and Certificates of Creditable Coverage, if

applicable, on or before the Effective Date of this Certificate. The Enrollment Date is the Effective Date of this Certificate.

B. If the employee becomes an Eligible Employee after the Effective Date of this Certificate, the employee must submit to Underwriters a completed Enrollment Form and Certificates of Creditable Coverage, if applicable, within thirty (30) days, beginning on the first day the employee becomes an Eligible Employee. The Enrollment Date is the date the Company receives the completed Enrollment Form and Certificates of Creditable Coverage, if applicable.

C. If an Eligible Employee does not enroll or Declines Enrollment, in accordance with A. or B. above, the Eligible Employee may become eligible for Special Enrollment, in accordance with Article 14 herein. The Enrollment Date is the date specified in the applicable provision.

D. If an Eligible Employee does not enroll or Declines Enrollment, in accordance with A. or B. above, and if the Eligible Employee is not eligible for Special Enrollment, in accordance with Article 14 herein, the Eligible Employee may enroll by submitting to Underwriters a completed Enrollment Form and Certificates of Creditable Coverage, if applicable. The Eligible Employee will be considered a Late Enrollee for purposes of application of the Pre-existing Condition Exclusion contained herein. The Enrollment Date is the date the Company receives the completed Enrollment Form and Certificates of Creditable Coverage, if applicable.

EFFECTIVE DATE: EMPLOYEE WITH REGULAR ENROLLMENT

The Effective Date of Coverage for Employees is the date the Employee is entitled to receive benefits under this insurance. The Effective Date of Coverage for Employees with Regular Enrollment is the later of:

A. For Eligible employees added after the Effective Date of this Certificate, the date following the Waiting Period specified on the Declaration attached to this Certificate; or

B. The Effective Date of this Certificate; or

C. The Enrollment Date.

TERMINATION OF COVERAGE: EMPLOYEE

Termination of Coverage for Employees is the date the Employee ceases to be entitled to receive benefits under this insurance. Termination of Coverage for Employees is the earlier of:

A. The date the employee no longer meets the Eligibility requirements set forth in Article 6 herein; or

B. The last day for which premium has been paid; or

C. The date this Certificate is terminated in accordance with Article 3 herein; or

D. Twelve months following the Employee's return to the United States.

ELIGIBILITY: DEPENDENT

In order to be an Eligible Dependent, the following conditions must be met:

A. The dependent must be a Dependent, as defined herein, of an Active Full-time employee, as defined herein.

REGULAR ENROLLMENT OF ELIGIBLE DEPENDENT

Only Eligible Dependents may enroll for coverage hereunder. In order to enroll, the dependent must:

A. If the dependent is an Eligible Dependent on the day immediately preceding the Effective Date of this Certificate, the dependent must submit to Underwriters a completed Enrollment Form and Certificates of Creditable Coverage, if applicable, on or before the Effective Date of this Certificate. The Enrollment Date is the Effective Date of this Certificate.

B. If the employee becomes an Eligible Employee after the Effective Date of this Certificate, the Eligible Dependent of the Eligible Employee must submit to Underwriters a completed Enrollment Form and Certificates of Creditable Coverage, if applicable, within thirty (30) days, beginning on the first day the employee becomes an Eligible Employee. The Enrollment Date is the date Underwriters receive the completed Enrollment Form and Certificates of Creditable Coverage, if applicable.

C. If an Eligible Dependent does not enroll or Declines Enrollment in accordance with A. or B. above, the Eligible Dependent may become eligible for Special Enrollment, in accordance with Article 14 herein. The Enrollment Date is the date specified in the applicable provision of this Certificate.

D. If an Eligible Dependent does not enroll or Declines Enrollment, in accordance with A. or B. above, and if the Eligible Dependent is not eligible for Special Enrollment, in accordance with Article 14 herein, the Eligible Dependent may enroll by submitting to Underwriters a completed Enrollment Form and Certificates of Creditable Coverage, if applicable. The Eligible Dependent will be considered a Late Enrollee for purposes of application of the Pre-existing Condition Exclusion contained herein. The Enrollment Date is the date Underwriters receive the completed Enrollment Form and Certificates of Creditable Coverage, if applicable.

EFFECTIVE DATE: DEPENDENT WITH REGULAR ENROLLMENT

The Effective Date of Coverage for Dependent is the date the Dependent is entitled to receive benefits under this insurance. The Effective Date of Coverage for Dependents with Regular Enrollment is the later of:

A. For Eligible Dependents added after the Effective Date of this Certificate, the date following the Waiting Period specified on the Declaration attached to this Certificate; or

B. The Effective Date of this Certificate; or

C. The Enrollment Date.

TERMINATION OF COVERAGE: DEPENDENT(S)

Termination of Coverage for Dependents is the date the Dependent(s) ceases to be entitled to receive benefits under this insurance. Termination of coverage for Dependent(s) is the earlier of:

A. The date the Dependent no longer meets the Eligibility requirements set forth in Article 10 herein; or

B. The last day for which premium has been paid; or
C. The date this Certificate is terminated in accordance with Article 3 herein; or
D. Twelve months following the Employee's return to the United States.

SPECIAL ENROLLMENT PERIODS: ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS

A. CONDITIONS FOR SPECIAL ENROLLMENT: An Eligible Employee or Eligible Dependent is eligible for Special Enrollment under this insurance if all of the following applicable conditions is met:
   1. When the employee Declined enrollment for the Eligible Employee or the Eligible Dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for Declining enrollment, provided that such a written statement was required of the employee and provided that the employee was provided with notice of the requirement for such a written statement at the time the employee Declined enrollment; and
   2. When the employee Declined enrollment for the Eligible Employee or the Eligible Dependent, the Eligible Employee or Eligible Dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or
   3. If the other coverage that applied to the Eligible Employee or the Eligible Dependent when enrollment was Declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated. For this purpose, loss of eligibility for coverage includes loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause.

B. LENGTH OF SPECIAL ENROLLMENT PERIOD – An Eligible Employee is required to request enrollment for the Eligible Employee or the Eligible Dependent within thirty (30) days of the date the CONDITIONS FOR SPECIAL ENROLLMENT described in A. above are met. In order to request enrollment under this provision the Eligible Employee or the Eligible Dependent must provide Underwriters with a completed Special Enrollment Form and Certificates of Creditable Coverage, if applicable, for receipt by Underwriters within thirty (30) days of the date the CONDITIONS FOR SPECIAL ENROLLMENT are met. The Enrollment Date is the date Underwriters receive the completed Special Enrollment Form and Certificates of Creditable Coverage, if applicable.

SPECIAL ENROLLMENT FOR CERTAIN DEPENDENT BENEFICIARIES

Certain Dependent Beneficiaries are eligible for Special Enrollment provided they meet one or more of the following conditions and provided Underwriters receive a completed

Special Enrollment Form including Certificates of Creditable Coverage if applicable, within thirty (30) days of meeting one of the following conditions:

A. SPECIAL ENROLLMENT OF AN ELIGIBLE EMPLOYEE WHO DECLINED REGULAR ENROLLMENT: An Eligible Employee who Declined Regular Enrollment is eligible for Special Enrollment if the Employee acquires an Eligible Dependent through marriage, birth, adoption or placement for adoption.

B. SPECIAL ENROLLMENT OF A SPOUSE OF A COVERED EMPLOYEE: An individual is eligible for Special Enrollment if the individual either:
   i. Becomes a Spouse of a Covered Employee; or
   ii. Is a Spouse of a Covered Employee and child becomes an Eligible Dependent of the Covered Employee through birth, adoption or placement for adoption.

C. SPECIAL ENROLLMENT OF AN ELIGIBLE EMPLOYEE WHO DECLINED REGULAR ENROLLMENT AND THE SPOUSE OF SUCH ELIGIBLE EMPLOYEE: An Eligible Employee who Declined Regular Enrollment and an individual who is an Eligible Dependent of such Eligible Employee are eligible for Special Enrollment if either:
   i. The Eligible Employee and the individual become married; or
   ii. The Eligible Employee and the individual are married and a child becomes a dependent of the Eligible Employee through birth, adoption or placement for adoption.

D. SPECIAL ENROLLMENT OF A DEPENDENT OF A COVERED EMPLOYEE: An individual who is a Dependent of a Covered Employee who becomes an Eligible Dependent of such Covered Employee through marriage, birth, adoption or placement for adoption is eligible for Special Enrollment.

E. SPECIAL ENROLLMENT OF AN ELIGIBLE EMPLOYEE WHO DECLINED REGULAR ENROLLMENT AND A NEW ELIGIBLE DEPENDENT: An Eligible Employee who Declined Regular Enrollment, and an individual who is an Eligible Dependent of the Eligible Employee are eligible for Special Enrollment if the individual becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or placement for adoption.

F. ENROLLMENT DATE FOR SPECIAL ENROLLMENT: In the event of Special Enrollment under this provision, the Enrollment Date is the Date Underwriters receive a completed Special Enrollment Form, including Certificates of Creditable Coverage, if applicable.

G. EFFECTIVE DATE OF COVERAGE FOR SPECIAL ENROLLMENT: In the event of Special Enrollment under this provision, the Effective Date of Coverage shall be:
   i. In the case of marriage, the first day of the first calendar month beginning after the date the completed Special Enrollment Form is received by Underwriters; or
   ii. In the case of a Dependent's birth, the date of such birth; or
   iii. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

ELIGIBLE PARTICIPATING ORGANIZATIONS

A corporation or other organization or division thereof principally engaged in commercial or service activity outside the United States of America is eligible to become a Participating Organization if it meets all of the following requirements:

A. It makes Application to participate or renew participation as a Participating Organization on a form provided by Underwriters, and is accepted as a Participating Organization by Underwriters and receives a Certificate issued by Underwriters; and

B. It agrees to insure at least 80% of its Eligible Employees under this insurance with a minimum level not falling below 3 Employee units; and

C. It agrees to remit audited invoices with one Premium payment per month for all Insured Persons; and

D. It will require that all Eligible Employees and Dependents provide Underwriters with completed Enrollment Forms including Certificates of Creditable Coverage, if applicable, as evidence of Enrollment or Decline of Enrollment under this insurance; and

E. It will provide each and every Eligible Employee and Dependent who enrolls with a Summary of Benefits, as provided by Underwriters; and

F. It will provide each and every Eligible Employee and Dependent who Declines Enrollment with a complete copy of the Certificate.

SCHEDULE OF BENEFITS AND LIMITS

BENEFIT	LIMIT
Deductible	All Deductibles are per Insured Person per Calendar Year, with a maximum of 3 Deductibles per family per Calendar Year. Deductible options are: $150, $250, $500, $1,000, $2,500, $5,000, or $10,000
Coverage Area Options	A. Worldwide B. Outside US and Canada only
Deductible Carry Forward	Expenses incurred during the last three months of a Calendar Year will be applied toward satisfaction of the Deductible for the next Calendar Year but only if the Deductible was not met during the prior Calendar Year
Coinsurance – Claims incurred in US or Canada	After the Deductible, Underwriters will pay 60%, 80%, or 90% of Eligible Medical Expenses up to $5,000, then 100% to the Maximum Limit per Insured Person. The Coinsurance will be waived if expenses are incurred within the PPO and expenses are submitted to Underwriters for review and payment directly to the provider
Coinsurance – Claims incurred outside US or Canada	After the Deductible, Underwriters will pay 100% of Eligible Medical Expenses up to the Maximum Limit per Insured Person

Maximum Limit	$1,000,000 Lifetime or $5,000,000 Lifetime
Inpatient Prescription Drugs	Usual, Reasonable and Customary (Subject to Deductible and Coinsurance)
Transplant Expense	Subject to Special Transplant Pre-certification Requirements, and only when treatment is provided within the PPO. Covered Transplants are: Heart, Heart/Lung, Lung, Kidney, Kidney/Pancreas, Liver and Allogeneic and Autologous Bone Marrow
Second Surgical Opinion	Subject to Deductible and Coinsurance unless requested by Underwriters (payable at 100% if requested by Underwriters)
Maternity and Newborn Care	Subject to Special Maternity Pre-certification requirements, same as any other illness after 10 months of continuous coverage
Hospital Room and Board	Average Semi-private, including nursing service
Intensive Care Unit	Usual, Reasonable and Customary
Physical Therapy	$50 Maximum per visit charge
Local Ambulance	$3,000 Maximum per Calendar Year
Eligible Medical Expenses	Usual, Reasonable and Customary
Pre-certification	Maternity and Newborn Care: 50% penalty in addition to Deductible and Coinsurance if Pre-certification Requirements are not met within the first 90 days of Pregnancy. Transplant: 100% penalty and forfeiture of benefits if Pre-certification Requirements are not met. All Other: 50% Penalty in addition to Deductible and Coinsurance if Pre-certification Requirements are not met

PRE-CERTIFICATION REQUIREMENTS

A. General Requirements: To comply with the Pre-certification requirements, the Insured Person must:

1. Contact the Plan Administrator as soon as possible before the expense is to be incurred (see Maternity Pre-Certification Requirements and Transplant Pre-certification Requirements); and
2. Comply with the instructions of the Plan Administrator and submit any information or documents required by Underwriters; and
3. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Plan Administrator.

If the Insured Person complies with the Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions herein.

If the Insured Person does not comply with the Pre-certification requirements, or if the expenses are not Pre-certified:

1. Eligible Medical Expenses claims will be reduced by 50%; and
2. The Deductible will be subtracted from the remaining amount; and

3. The Coinsurance will be applied.

The following expenses must always be Pre-certified:

1. Maternity (see Maternity Pre-certification Requirements); and
2. Transplants (see Transplant Pre-certification Requirements); and
3. Inpatient care; and
4. any Surgery or Surgical Procedure; and
5. care in an Extended Care Facility; and
6. Home Nursing Care; and
7. Durable Medical Equipment; and
8. artificial limbs; and
9. Computerized Tomography (CAT Scan); and
10. Magnetic Resonance Imaging (MRI).

B. Maternity Pre-certification Requirements – To comply with the Maternity Pre-certification Requirements, the Insured Person must:

1. Contact the Plan Administrator as soon as possible but always within the first 90 days of Pregnancy; and
2. Comply with the instructions of the Plan Administrator and submit any information or documents required by Underwriters; and
3. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Plan Administrator.

If the Insured Person complies with the Maternity Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Maternity and Newborn Care benefits subject to all terms, conditions, provisions and exclusions herein.

If the Insured Person does not comply with the Maternity Pre-certification requirements, or if the expenses are not Pre-certified:

1. Maternity and Newborn Care benefits will be reduced by 50%; and
2. The Deductible will be subtracted from the remaining amount; and
3. The Coinsurance will be applied.

If, for any reason after the initial Maternity Pre-certification, the Insured Person shall become aware of complications during Pregnancy, the Insured Person must Pre-certify again, in accordance with the General Requirements for Pre-certification.

C. Transplant Pre-certification Requirements: To comply with the Transplant Pre-certification requirements, the Insured Person must:

1. Contact the Plan Administrator as soon as possible but always within 72 hours of becoming a candidate for a Covered Transplant; and
2. Comply with the instructions of the Plan Administrator and submit any information or documents required by Underwriters; and
1. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Plan Administrator.

If the Insured Person complies with the Transplant Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Transplant benefits subject to all terms, conditions, provisions and exclusions herein.

If the Insured Person does not comply with the Transplant Pre-certification requirements, or if the expenses are not Pre-certified, all Transplant benefits are forfeited.

D. Emergency Pre-certification: In the event of an Emergency Hospital admission, Pre-Certification must be made within 48 hours after the admission, or as soon as is reasonably possible.

E. Pre-certification Does Not Guarantee Benefits – The fact that expenses are Pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.

F. Concurrent Review – For Inpatient stays of any kind, the Plan Administrator will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if an Insured Person receives prior approval.

UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO) REQUIREMENTS

Nothing contained in this insurance restricts or interferes with the Insured Persons' right to select the Hospital, Physician or other medical service provider of the Insured Persons choice. Nothing contained in this insurance restricts or interferes with the relationship between the Insured Person and the Hospital, Physician or other providers with respect to treatment or care of any condition, nor the right of any Insured Person to receive, at his or her own expense, services and/or supplies that are not covered under this insurance.

To comply with the United States Preferred Provider Organization requirements, the Insured Person must receive medical treatment from PPO providers while in the United States. If the Insured Person chooses to seek treatment from a PPO provider, Underwriters will remit payment for eligible expenses directly to the provider and will waive the Coinsurance applicable to the expenses. Notwithstanding the foregoing, Transplant benefits are payable only when expenses are incurred at PPO providers.

An Insured Person may review a listing of facilities and physicians contained in the PPO Network for the area where the Insured Person will be receiving treatment by accessing the Internet website for HCC Medical Insurance Services, LLC at: www.hccmis.com.

CONDITIONS PRECEDENT

Notice of Claim, Claimant's Statements, and Proof of Claim must be mailed to:
HCC Medical Insurance Services, LLC
P.O. Box 863
Indianapolis, Indiana 46206

The following are conditions precedent to Underwriter's liability under this insurance:

A. PREMIUM

1. Payment: Payment of required Premium shall be remitted to Underwriters on or before the Due Dates specified in this Certificate. The first Premium payment is due and payable on the Effective Date of this Certificate and subsequent Premiums shall be due and payable monthly on the first day of each month thereafter unless otherwise specified on the Declaration attached to this Certificate.
2. Grace Period: A grace period of 30 days will be allowed for the payment of each Premium except the first.
3. Non-payment: If any Premium is unpaid at the end of a Grace Period, all insurance shall terminate and Underwriters liability shall cease with effect from the Due Date of the unpaid Premium. Premium is considered to be paid on the date the payment instrument is received by the Company.
4. Premium shall be calculated in whole month increments and shall be due and payable for all Insured Persons who are Enrolled and approved by the Company as of the first day of the month for which Premium is due.
5. The Premium is specified on the Declaration of this Certificate issued to the Participating Organization.

B. MISREPRESENTATION AND FRAUD

1. Application:
   Underwriters rely on the statements made by the Participating Organization on the Participating Organization Application and the Insured Person on the Enrollment form and in connection with the making of the Enrollment and/or Participating Organization Application in determining whether or not the individual(s) included on the Enrollment meets the Eligibility requirements and the underwriting requirements for insurance hereunder. Any misstatement, concealment or fraud in the Insured Person's Enrollment and/or Participating Organization Application, or in relation to any statement or warranty made by the Participating Organization, Insured Person or their authorized representative, whether in writing or otherwise, to Underwriters or their representatives, on or in connection with the Enrollment and/or Participating Organization Application shall render this insurance null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters.
2. Claims:
   Underwriters rely on the statements made by the Insured Person on the Claimant's Statement and in connection with the submission of any claim

hereunder in determining whether or not and to what extent benefits under this insurance may be payable. Any misstatement, concealment or fraud in the making of any claim hereunder shall render this insurance null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters. If any claim under this insurance shall be in any respect fraudulent or if any fraudulent means or devices are used by the Insured Person or anyone acting on their behalf, this insurance shall be null and void and all claims hereunder shall be forfeited, in addition to any and all other remedies available to Underwriters.

C. PROOF OF CLAIM

When Underwriters receive notice of claim, they will provide the Insured Person with forms for filing Proof of Claim. The following is considered to be Proof of Claim:

1. A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments; and
2. Original itemized bills from Physicians, Hospitals and other providers; and
3. Original receipts for any expenses which have already been paid by or on behalf of the Insured Person.

The Insured Person shall have 60 days beginning on the last day of the Certificate Period to submit Proof of Claim to Underwriters. Subsequent to receipt of Proof of Claim, Underwriters may, at their sole discretion, request and require additional information, including but not limited to medical records, necessary to confirm the validity of any claim prior to payment thereof.

D. APPEALING A CLAIM

1. TIME LIMIT

   In the event Underwriters deny all or part of a claim under this insurance, the Insured Person shall have 90 days from the date the notice of denial was mailed to the Insured Person's last known address to file a written appeal with Underwriters. The written appeal must include sufficient information to identify the claim under appeal and must specify the reason(s) for the appeal with supporting documentation, if applicable.

2. APPEAL PROCEDURE

   Within 30 days of Underwriters receipt of the appeal, Underwriters will review the claim. A written response will be forwarded to the Insured Person. Within 60 days of receipt of Underwriters response to the appeal, the Insured Person may initiate a second appeal. Within 30 days of Underwriters receipt of the second appeal, medical and/or claims personnel who were not involved in the original claim determination or the initial appeal will review the claim. A final determination will be made and a letter will be sent to the Insured Person.

E. ARBITRATION

If any dispute shall arise as to the amount to be paid under this insurance (liability being otherwise admitted), such dispute shall be referred to arbitration in accordance with procedures of the American Arbitration Association. Where any dispute is by this provision referred to arbitration, the making of an award shall be a condition precedent to any right of action against Underwriters.

F. LEGAL ACTIONS

No action of law or equity may be brought to recover benefits under this insurance until 60 days after written Proof of Claim, as herein defined, has been provided to Underwriters. No such action may be brought after the end of three (3) years after the time written Proof of Claim, as herein defined, is required to be furnished.

G. WAIVER OF RIGHTS

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

H. CLAIMS COOPERATION

The Insured Person and his/her Physician(s), Hospital(s) and other providers shall cooperate fully with Underwriters including granting full right of access to all related medical documentation, reports and evidence. Underwriters may deny coverage for any claim where there has been a refusal or material failure to so cooperate.

I. PATIENT ADVOCACY

Underwriters may determine that a particular claim or diagnosis occurring under this insurance may be placed under the Patient Advocacy program to ensure that Medically Necessary services and supplies are provided in the most cost effective manner. In the event Underwriters determine that a claim or diagnosis meets the Patient Advocacy program requirements, Underwriters will notify the Insured Person, and a Patient Advocate will be assigned to the Insured Person. Thereafter, the Patient Advocate may make recommendations of alternative treatment settings and/or procedures and/or supplies, which may be more cost effective for the Underwriters and/or the Insured Person. Such recommendations will be made with input from the Insured Person and the Insured Person's Physician(s) and will be made only when it can be reasonably demonstrated that the Medically Necessary services and supplies can be provided in a more cost-effective manner to Underwriters and/or the Insured Person. Underwriters will use best efforts to evaluate and recommend alternative treatment settings and/or procedures and/or supplies, which can reasonably be expected to result in the same or better care of the Insured Person. The Insured Person, in accepting the recommendations, agrees to hold Underwriters harmless and Underwriters shall not be held liable or otherwise responsible for any treatment, service, supply, procedure or care provided to the Insured Person except for the payment of benefits under this insurance. After the Insured Person has been notified that the claim or diagnosis meets the Patient Advocacy program requirements, Underwriters reserve the rights to:

1. Make payment for treatments, services and/or supplies which are not covered under this insurance which would be beneficial to the Insured Person and cost effective to Underwriters; and
2. Deny payment for expenses which would otherwise be covered under this insurance which are over the amount Underwriters would have paid had the Insured Person followed the recommendations of the Patient Advocacy program.

J. SUBROGATION

The Participating Organization and Insured Persons undertake to cooperate with Underwriters in the prosecution of any and all valid claims they may have against third parties arising out of any occurrence which results or may result in a loss payment by Underwriters and to account for any amounts recovered on the basis that Underwriters shall be entitled to recover first in full any sums paid by them before the Participating Organization and Insured Person shares in any amount so recovered. Should the Participating Organization and Insured Person fail to prosecute any valid claims against third parties and Underwriters thereupon become liable to make payment under this insurance, then Underwriters shall be subrogated to all rights of the Participating Organization or Insured Person. Any amount recovered by Underwriters shall be used to pay the expenses of collection and reimbursement of Underwriters for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts shall be paid to the Participating Organization or Insured Person.

K. OTHER INSURANCE

Underwriters shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance, pay such claim. This insurance will apply for expenses in excess of the amount paid or payable under such other insurance. Underwriters shall not pay any claim in respect to care, treatment, services or supplies furnished by any program or agency funded by any government.

L. ASSIGNMENT

The Insured Person may assign benefits under this insurance to a Hospital, Physician or other provider. Any assignment shall not confer upon such Hospital, Physician or other provider any right or privilege granted to the Insured Person under this insurance except for the right to receive benefits, if any, which are determined to be due and payable hereunder. No Hospital, Physician or other provider shall have any direct or indirect claim or right of action against Underwriters or the Plan Administrator.

M. RIGHT OF RECOVERY

In the event of overpayment of any claim hereunder because:

1. all or some of the expenses were not paid for by or on behalf of the Insured Person or were subsequently recovered by or on behalf of the Insured Person; or
2. any Relative of the Insured Person or any person in the Insured Person's family, whether or not that person is or was an Insured Person, is repaid for all or some of those expenses by a source other than Underwriters; or

3. all or some of the expenses were not Eligible Expenses; or
4. all or some of the expenses were paid or reimbursed based on incorrect benefit application, Underwriters have the right to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician or other provider of services or supplies. The amount of the recovery is the difference between:
    a. the amount of expenses actually paid by Underwriters; and
    b. the amount of expenses which should have been paid by Underwriters.

If the Insured Person or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to Underwriters, Underwriters may, in addition to any other remedies available to them, either:

1. reduce the amount of any future claim that is otherwise eligible for payment hereunder, to the full extent of the refund due Underwriters; or
2. cancel the Certificate issued to the Insured Person by giving 30 days advance written notice by mail to the Insured Person's last known address.

N. CLAIMS ASSISTANCE

Every attempt will be made to help Insured Persons understand the benefits provided by this insurance, however, any statement made by an employee of Underwriters or the Plan Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time proper and complete Proof of Claim is submitted and all facts are presented in writing. If a definite answer to a specific question is required, the Insured Person can submit a written request, including all pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent to the Insured Person and kept on file.

ELIGIBLE MEDICAL EXPENSES

Subject to the Deductible, Coinsurance, Limits, set forth in the ARTICLE 17– SCHEDULE OF BENEFITS AND LIMITS, Underwriters will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
    a. Daily room and board and nursing services in a semi-private room; and
    b. Daily room and board and nursing services in an Intensive Care Unit; and
    c. Use of operating, treatment or recovery room; and
    d. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatient; and
    e. Emergency treatment of an Injury, even if Hospital confinement is not required; and
    f. Emergency treatment of an Illness; however, charges for use of the emergency room itself will not be covered unless the Insured Person is directly admitted to the Hospital as Inpatient for further treatment of that Illness or is located outside the United States at time of emergency treatment; and

2. For Surgery at an Outpatient surgical facility, including services and supplies; and
3. Charges made by a Physician for professional services, including Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual, Reasonable and Customary charge of the primary surgeon, but standby availability will not be deemed to be a professional service; and
4. For dressings, sutures, casts or other supplies which are Medically Necessary; and
5. For diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included); and
6. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, but not the replacement or repair thereof; and
7. For Reconstructive Surgery when the Surgery is directly related to Surgery or Accident which is covered hereunder. For the purpose of this coverage, Reconstructive Surgery means Surgery performed on abnormal body structures caused by trauma, infection, tumors or disease to correct adverse physical effects. Reconstructive Surgery will also include breast Reconstructive Surgery following a covered mastectomy and skin grafts following a covered Accident; and
8. For radiation therapy or treatment and chemotherapy; and
9. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components; and
10. For oxygen and other gasses and their administration; and
11. For anesthetics and their administration by a Physician; and
12. For care in a licensed Extended Care Facility upon direct transfer from an acute care Hospital; and
13. Home Nursing Care in bed by a qualified licensed professional, provided by a Home Health Care Agency upon direct transfer from an acute care Hospital; and
14. Emergency Local Ambulance transport necessarily incurred in connection with Injury or Illness resulting in Hospitalization and subject to the Limits set forth in the Schedule of Benefits and Limits; and
15. Emergency Dental Treatment and Dental Surgery necessary to restore or replace sound natural teeth lost or damaged in an Accident which was covered under this insurance; and
16. For routine and Medically Necessary care of Newborns of a covered Employee or an Employee's covered spouse during the first 31 days of life provided the Pregnancy and Delivery of the Newborn is covered hereunder; and
17. For pre-natal care, delivery of Newborn of a covered Employee or an Employee's covered spouse, and post-natal care provided the Insured Person has been continuously insured hereunder for not less than 10 continuous months immediately preceding treatment; and
18. For charges for physical therapy performed by a licensed professional physical therapist prescribed by a Physician necessarily incurred to continue recovery from a covered Injury or Illness; and
19. Medically Necessary rental of Durable Medical Equipment (consisting of a standard basic hospital bed and or a standard basic wheelchair) up to the purchase prices; and
20. The following Human Organ/Tissue Transplant-related expenses:

Underwriters will pay Eligible Medical Expenses for the Covered Transplants, in addition to the following expenses, but always subject to the Limits set forth in the Schedule of Benefits and Limits:

A. Eligible Medical Expenses incurred by a live donor will be treated as if they were the expenses of the Insured Person receiving the Transplant if the Insured Person received an organ or tissue of the live donor; and
B. Organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a Lifetime Maximum of $10,000; and
C. Reasonable travel and lodging expenses of the Insured Person if travel of more than 100 miles is necessary to receive Transplant treatment and services, up to a Lifetime Maximum of $5,000.

EXCLUSIONS

War, Terrorism, Biological, Chemical, Radioactive, Nuclear: Notwithstanding any provision to the contrary within this insurance or any endorsement or rider attached hereto, it is agreed that this insurance excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss, damage, cost or expense:

A. war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; or
B. any act of terrorism. For the purpose of this insurance, an "act of terrorism" means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear; or
C. the use of any biological, chemical, radioactive or nuclear agent, material, device or weapon. However, this exclusion (C) shall not apply where the Insured Person is exposed to nuclear radioactive and/or radioactive material for the purpose of medical treatment.

This insurance also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to (A), (B) or (C) above.

If Underwriters allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance, the burden of proving the contrary shall be upon the Insured Person.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

The following charges, treatments, care, services, supplies and/or conditions are excluded from coverage hereunder:

1. Pre-existing Conditions – Charges resulting directly or indirectly from any Pre-existing Condition, defined as a Condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received during the 6 month period ending on the Enrollment Date, are excluded from this insurance until the earlier of the following dates:
   A. 365 days beginning on the Enrollment Date; or
   B. The date that the number of days beginning on the Enrollment Date, when added to the number of days of Creditable Coverage beginning on the first day following any Significant Break in Creditable Coverage and ending on the Enrollment Date applicable to the individual, exceeds 365 days; or
   C. With respect to individuals who are covered under this insurance as Late Enrollees, the date that the number of days beginning on the Enrollment Date, when added to the number of days of Creditable Coverage beginning on the first day following any Significant Break in Creditable Coverage and ending on the Enrollment Date applicable to the individual, exceeds 546 days.
2. Maternity and Newborn Care: Charges for pre-natal care, delivery, post-natal care, and care of Newborns, are excluded from this insurance until the Insured Person has maintained coverage hereunder continuously for 10 months; and
3. Charges for routine and Medically Necessary care of Newborns are excluded unless the Delivery of the Newborn is covered hereunder; and
4. Mental Health Disorders: Charges for treatment of Mental Health Disorders are excluded from this insurance; and
5. Wellness: Charges for Routine Physical Exams are excluded from this insurance; and
6. Charges which are not incurred by an Insured Person while insured hereunder; and
7. Charges for any benefit hereunder which are not presented to Underwriters for payment within 90 days of the date incurred (or as soon as is reasonably possible); and
8. Treatment, services or supplies which are not administered or ordered by a Physician; and
9. Treatment, services or supplies which are not Medically Necessary; and
10. Treatment, services or supplies provided at no cost to the Insured Person; and
11. Charges which exceed Usual, Reasonable and Customary; and
12. Telephone consultations or failure to keep a scheduled appointment; and
13. Surgeries, treatments, services or supplies which are Investigational, Experimental or for Research Purposes; and
14. While confined primarily to receive Custodial Care, Educational or Rehabilitative Care; and
15. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass Surgery; and

16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person such as sex-change Surgery; and
17. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is directly related to and follows a Surgery which was covered hereunder; and
18. Treatment of Insured Persons who were HIV+ at their initial Effective Date of Coverage, whether or not the Insured Person had knowledge of his/her HIV status; and
19. Outpatient Prescription Drugs; and
20. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization; and
21. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction; and
22. Willful and/or therapeutic termination of Pregnancy; and
23. Dental Treatment, except for Emergency Dental Treatment necessary to replace sound natural teeth lost or damaged in an Accident covered hereunder; and
24. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, or for any examination or fitting related to these devices; and
25. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism; and
26. Treatment of the temporomandibular joint; and
27. Routine care of Newborns after the first 31 days of life; and
28. Injury resulting from participation in the following activities:
    a. Amateur Athletics, Contact Sports, and professional sports or athletic activities. Non-contact and non-organized/non-sanctioned amateur sports or athletic activities engaged in by the Insured Person solely for leisure, recreational, entertainment or fitness purposes are not excluded unless they are excluded by (b) through (j) of this provision; and
    b. mountaineering where ropes or guides are normally used or at elevations of 4,500 meters or higher; and
    c. aviation (except when traveling solely as a passenger in a commercial aircraft); and
    d. hang gliding, sky diving, parachuting or bungee jumping; and
    e. snow skiing or snowboarding, except for recreational downhill and/or cross country snow skiing or snowboarding (no cover provided whilst skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body); and
    f. racing by any animal or motorized vehicle; and
    g. spelunking; and
    h. subaqua pursuits involving underwater breathing apparatus unless PADI/NAUI certified, accompanied by a certified instructor, and at depths of less than 10 meters; and
    i. jet skiing; and
    j. any other sport or athletic activity which is undertaken for thrill seeking and exposes the Insured Person to abnormal or extraordinary risk of Injury.

29. Injury sustained while under the influence of or due wholly or partly to the effects of intoxicating substances or drugs except drugs taken in accordance with Physician-prescribed treatment for eligible conditions; and
30. Willfully self-inflicted Injury or Illness; and
31. Voluntary testing for the following: HIV, seropositivity to the AIDS virus, AIDS related illnesses, ARC Syndrome, AIDS; and
32. Immunizations and Routine Physical Exams except for Newborns under the age of 31 days; and
33. Treatment by a chiropractor unless ordered in advance by a Physician; and
34. Charges resulting from or occurring during the commission of a violation of law by the Insured Person, including without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations; and
35. Treatment of Substance Abuse; and
36. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and
37. Any services or supplies performed or provided by a Relative of the Insured Person or any family Insured Person of the Insured Person or any person who ordinarily resides with the Insured Person; and
38. Orthoptics and visual eye training; and
39. Services or supplies which are not included as Eligible Expenses as described herein; and
40. The following care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails; and
41. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician; and
42. Treatment of sleep disorders; and
43. Exercise programs, whether or not prescribed or recommended by a Physician; and
44. Treatment required as a result of complications or consequences of a treatment or condition not covered hereunder; and
45. Charges for travel or accommodations, except as provided for in the Local Ambulance and Transplant sections of this insurance; and
46. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s); and
47. Human Organ or Tissue Transplants or related services, except for Covered Transplants; and
48. Artificial or mechanical devices designed to replace human organs temporarily or permanently; and
49. Expenses to keep a donor alive for a transplant procedure, whether or not the transplant procedure is a Covered Transplant; and
50. Transplant benefits for more than one Covered Transplant during any 12 month period, except re-transplantation if during initial transplant procedure.

51. Charges for use of Emergency Room for treatment of an Illness unless the Insured Person is directly admitted to the Hospital as Inpatient for further treatment of that Illness or is located outside the United States at time of emergency treatment.

DEFINITIONS

Accident: A sudden and unexpected occurrence resulting in Injury of the Insured Person.
Active Full-time (Employee): An employee of a Participating Organization who receives regular pay for services performed for the Participating Organization at the Participating Organization's usual place(s) of business, for at least thirty (30) hours per week during each week of a Calendar Year. Active Full-time (Employee) does not include employees who perform services for the Participating Organization for less than thirty (30) hours per week during each week of a Calendar Year, any employee classified by the Participating Organization as Part-time, temporary or seasonal.
AIDS: Acquired Immune Deficiency Syndrome as that term is defined by the United States Centers for Disease Control.
ARC: AIDS Related Complex as that term is defined by the United States Centers for Disease Control.
Amateur Athletics: A sport or other athletic activity that is organized and/or sanctioned, involving regular or scheduled practices and/or regular or scheduled games. This definition does not include athletic activities that are non-contact and engaged in by an Insured Person solely for recreational, entertainment or fitness purposes.
Application: The fully answered and signed Application which is attached to the Master Policy and the fully answered and signed Application which is attached to this Certificate issued to the Participating Organization.
Assured: The Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda.
Certificate: This document issued to the Participating Organization which provides evidence of benefits payable under the Master Policy, and which includes the Participating Organization's Application.
Certificate Period: The period of time beginning on the Certificate Effective Date and ending on the Certificate Termination Date, both days at 12:01am at the location of the Participating Organization.
Certificates of Creditable Coverage: A written document issued by a health insurance provider, in accordance with the Health Insurance Portability and Accountability Act of 1996, which certifies that the individual named in the document had health insurance coverage for a period of time which is specified in such certification. Certificates of Creditable Coverage are required with Regular Enrollment and Special Enrollment and Late Enrollment under this insurance. These must be obtained by the individual from the individual's prior health insurance provider(s). Certificates of Creditable Coverage are automatically issued by Underwriters and forwarded by first class mail to the last known address of any individual who becomes eligible for COBRA under this insurance, or any individual whose coverage under this insurance ends for any reason. Further, Certificates of Creditable Coverage are issued by Underwriters upon request by any individual insured hereunder, and after coverage hereunder ends for up to twenty-four months.

Creditable Coverage: Coverage of an individual as defined in the Health Insurance Portability and Accountability Act of 1996. Generally, this definition includes health insurance coverage and other health coverage, such as coverage under a group health plan, Medicaid, Medicare and United States public health plans. Generally, all forms of health insurance coverage are included, whether individual or group, and whether the coverage is short-term, limited duration coverage or other coverage for benefits for medical care for which no Certificate of Creditable Coverage is required under the provisions of the Health Insurance Portability and Accountability Act of 1996. Creditable coverage does not include coverage consisting solely of excepted benefits as defined in the Health Insurance Portability and Accountability Act of 1996. Generally, excepted benefits include limited-scope dental benefits, limited-scope vision benefits, long-term care benefits, specific disease or illness benefits and hospital indemnity or other fixed dollar indemnity benefits. This definition is provided as guidance only. Refer to the actual Health Insurance Portability and Accountability Act of 1996 for the actual and complete definition.

Coinsurance: The payment by the Insured Person of Eligible Expenses at the percentage specified in the Schedule of Benefits and Limits.

Contact Sports: A sport or other athletic activity that necessarily involves physical contact with opposing players as part of normal play. Contact Sports include but are not limited to American football, boxing, ice hockey, rugby, soccer, and wrestling.

Covered Transplant: Heart, Heart/Lung, Lung, Kidney, Kidney/Pancreas, Liver, and Allogenic and Autologous Bone Marrow.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist an Insured Person.

Declaration: The Declaration is attached to and forms a part of the Master Policy, and the Declaration is attached to and forms a part of this Certificate issued to the Participating Organization.

Deductible: The dollar amount of Eligible Expenses, specified in the Schedule of Benefits and Limits, that the Insured Person must pay per Calendar Year.

Dental Treatment: The care of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

Dependent: The term "Dependent" means the Insured Person's legal spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage of such parties. The term "Dependent" also means the Insured Person's child who meets all of the following conditions: is unmarried; is a natural child, stepchild, legally adopted child, or a child who has been placed under the legal guardianship of the Insured Person; and is considered a "Dependent" of the Insured Person for tax exemption purposes under Section 152 of the Internal Revenue Code of 1986 as amended. This requirement is waived if the Insured Person is obligated to provide medical care coverage for the child under an order or judgement of a court of competent jurisdiction; and is less than nineteen years of age. This requirement is waived if the child is at least nineteen years of age but less than twenty-three years of age, is dependent upon the Insured Person for support, and is a Full-time Student. The age requirement above is also waived for any mentally retarded or physically handicapped child who is incapable of self-sustaining employment and is chiefly dependent upon the Insured Person for support and maintenance, provided the child suffered such incapacity prior to attaining nineteen years

of age. Proof of incapacity must be furnished to Underwriters, and additional proof may be requested from time to time.
The term "Dependent" excludes these situations: A spouse who is legally separated or divorced from the Insured Person. Such spouse must have met all requirements of a valid separation agreement or divorce decree in the state granting such separation or divorce; and/or any person on active military duty; and/or any person who is covered under this insurance as an individual Insured Person.
Durable Medical Equipment: A standard basic hospital bed and/or a standard basic wheelchair.
Educational or Rehabilitative Care: Care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to, vocational or occupational therapy and speech therapy.
Effective Date of Certificate: The date, specified on the Certificate issued to the Participating Organization, on and after which the Eligible Employees and/or Dependents of the Participating Organization are entitled to receive benefits under this insurance.
Effective Date of Coverage: The date the Eligible Employee or Eligible Dependent is entitled to receive benefits under this insurance.
Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.
Enrollment: An Eligible Employee or an Eligible Dependent completes an Enrollment Form and provides same to Underwriters, together with Certificates of Creditable Coverage, if applicable, as evidence of the Eligible Employee's or Eligible Dependent's desire to become covered hereunder.
Enrollment Form: The form, provided by Underwriters, to be completed and signed by an Eligible Employee or Eligible Dependent, and provided to Underwriters as evidence of the Eligible Employee or Eligible Dependent's desire to become covered or to decline Enrollment under this insurance during Regular Enrollment.
Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a Hospital, Extended Care Facility or rehabilitation facility by the state in which it operates; and is regularly engaged in providing 24 hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a Physician; and provides each patient with active treatment of an Illness or Injury. Extended Care Facility does not include a facility primarily for rest, the aged, Substance Abuse treatment, Custodial Care, nursing care or for care of Mental Health Disorders or the mentally incompetent.
Full-time Student: A person who is enrolled in and regularly attends an accredited college or university or other educational institution for the minimum number of credit hours required by the accredited college or university or other educational institution in order to maintain a Full-time Student status.
HIV+: Laboratory evidence defined by the United States Centers for Disease Control as being positive for Human ImmunodeficiencyVirus infection.
Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law and is regularly engaged in providing Home Nursing Care

under the supervision of a Registered Nurse, and maintains a daily record on each patient, and provides each patient with a planned program of observation and treatment by a Physician.

Home Nursing Care: Services provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient, provided always that such care is provided in lieu of Medically Necessary Inpatient care in a Hospital.

Hospital: An institution which operates as a hospital pursuant to law, and is licensed by the State or Country in which it operates; and operates primarily for the reception, care and treatment of sick or injured persons as Inpatients; and provides 24-hour nursing service by Registered Nurses on duty or call; and has a staff of one or more Physicians available at all times; and provides organized facilities and equipment for diagnosis and treatment of acute medical conditions on its premises; and is not primarily a long-term care facility, Extended Care Facility, nursing, rest, Custodial Care or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

Illness: A sickness or disease. Illness does not include learning disabilities, attitudinal disorders or disciplinary problems.

Incurred: A charge is incurred on the date the service is provided or the supply is purchased.

Injury: Bodily Injury resulting from an Accident.

Inpatient: A person who is an overnight resident patient of a Hospital, using and being charged for room and board.

Insured Person: An Eligible Employee or an Eligible Dependent, on and after their Effective Date of Coverage.

Intensive Care Unit: A Cardiac Care Unit or other unit or area of a Hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Investigational, Experimental or for Research Purposes: Terms used to describe procedures, services or supplies that are by nature or composition, or are used or applied, in a way which deviates from generally accepted standards of current medical practice.

Medically Necessary: A service or supply which is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice as determined by Underwriters. A service or supply will not be considered Medically Necessary if it is provided only as a convenience to the Insured Person or provider, and/or is not appropriate for the Insured Person's diagnosis or symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment of an Illness or Injury.

Mental Health Disorder: A mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. Mental Health Disorders include: psychosis, depression, schizophrenia, bipolar affective disorder, and those psychiatric illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Newborn: An infant from the moment of birth through the first 31 days of life.

Outpatient: An Insured Person who receives Medically Necessary treatment by a Physician for Injury or Illness that does not require overnight stay in a Hospital.
Participating Organization: The organization specified on the Declaration of this Certificate that meets all of the requirements of Article 2 who has been accepted in writing by Underwriters.
Physician: A doctor of Medicine (MD), doctor of Dental Surgery (DDS), doctor of Dental Medicine (DDM), doctor of Podiatry (DPM), doctor of Osteopathy (DO), doctor of Chiropractic (DC), a licensed Physical Therapist or Physiotherapist, and a doctor of Psychiatry (Psy.D) and a doctor of Psychology (Ph.D). Physician also includes a Certified Nurse Practitioner (CNP) under the direction of a Medical Doctor for Outpatient services. A Physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license.
Plan Administrator: HCC Medical Insurance Services, LLC, 251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204, Telephone (800) 605-2282, Fax (317) 262-2140.
Pre-existing Condition: A medical condition, whether physical or mental, and regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 6 month period ending on the Enrollment Date.
Pregnancy: The physical condition of being pregnant.
Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." after his or her name.
Relative: Biological or stepparent, current spouse, biological or stepsiblings.
Routine Physical Exam: Examination of the physical body by a Physician for preventative or informative purposes only, and not for the diagnosis or treatment of any condition.
Significant Break (in Creditable Coverage): A period of sixty three consecutive days during all of which the individual did not have any Creditable Coverage.
Substance Abuse: Alcohol, drug or chemical abuse, overuse or dependency.
Surgery or Surgical Procedure: An invasive diagnostic procedure; or the treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.
US: The United States of America including all states, districts, and possessions.
Usual, Reasonable and Customary: The most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are Reasonable. What is defined as Usual, Reasonable and Customary Charges will be determined by Underwriters. In determining whether a charge is Usual, Reasonable and Customary, Underwriters may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the Illness or Injury being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors as Underwriters, in the reasonable exercise of discretion, determine are appropriate.