**HTH Health Insurance Policy**

**University of Scranton Study Abroad Program**

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**SECTION 1**

**SCHEDULE OF BENEFITS**

**ELIGIBLE CLASSES**

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

 **X** Class I: Study Abroad Student Eligible Participants enrolled in the educational institution’s sponsored or approved study abroad program and their Eligible Dependents.

 **X** Class II Study Abroad Staff Eligible Participants providing direct support to the educational institution’s sponsored or approved study abroad program at its Country of Assignment location and their Eligible Dependents.

All benefits and limits are stated per Covered Person

# SCHEDULE OF BENEFITS

# TABLE 1

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Limits****Eligible Participant** | **Limits****Spouse**  | **Limits****Child** |
| **COVERAGE A –** **MEDICAL EXPENSES** |  |  |  |
| **Lifetime Maximum Benefit** | $1,000,000 | $1,000,000 | $1,000,000 |
| **Policy Year Maximum Benefits** | $100,000 | $100,000 | $100,000 |
| **Maximum Benefit per Injury or Sicknesses**  | $100,000 | $100,000 | $100,000 |
| **Deductible** | $0 per Injury or Sickness | $0 per Injury or Sickness | $0 per Injury or Sickness |
| **COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT** | Maximum Benefit:Principal Sum up to $10,000 | Maximum Benefit:Principal Sum up to $5,000 | Maximum Benefit:Principal Sum up to $1,000 |
| **COVERAGE C – REPATRIATION OF REMAINS** | Maximum Benefit up to $25,000 | Maximum Benefit up to $25,000 | Maximum Benefit up to $25,000 |
| **COVERAGE D –** **MEDICAL EVACUATION** | Maximum Lifetime Benefit for all Evacuations up to $75,000 | Maximum Lifetime Benefit for all Evacuations up to $75,000 | Maximum Lifetime Benefit for all Evacuations up to $75,000 |
| **COVERAGE E –** **BEDSIDE VISIT** | Up to a maximum benefit of $1,500 for the costof one economy round‑trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person | Up to a maximum benefit of $1,500 for the costof one economy round‑trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person | Up to a maximum benefit of $1,500 for the costof one economy round‑trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person |

**SCHEDULE OF BENEFITS**

**TABLE 2**

|  |  |
| --- | --- |
| **COVERAGE A –** **MEDICAL EXPENSES** | Indemnity Plan Limits |
| **Physician Office Visits** | 100% of Reasonable Expenses |
| **Inpatient Hospital Services**  | 100% of Reasonable Expenses |
| **Hospital and Physician Outpatient Services** | 100% of Reasonable Expenses |

**SCHEDULE OF BENEFITS**

**TABLE 3**

**COVERAGE A – MEDICAL EXPENSE BENEFITS**

|  |
| --- |
| **BENEFITS LISTED BELOW ARE SUBJECT TO****1. TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;****2. TABLE 2 PLAN TYPE LIMITS (INDEMNITY)** |
| **MEDICAL EXPENSES** | **COVERED PERSON** |
| **Maternity Care for a Covered Pregnancy** | Reasonable Expenses Conception must have occurred while the Covered Person was insured under the Policy. |
| **Inpatient treatment of mental and nervous disorders including drug or alcohol abuse** | Reasonable Expenses up $2,500 Maximum per Lifetime for a Maximum period of 30 days per Lifetime |
| **Outpatient treatment of mental and nervous disorders including drug or alcohol abuse** | Reasonable Expenses up to $500 Maximum per Lifetime  |
| **Treatment of specified therapies, including acupuncture and Physiotherapy** | Reasonable Expenses up to $5,000 Maximum combined total for Inpatient and Outpatient care, up to 30 days immediately following the attending Physician’s release for rehabilitation following a covered Hospital Confinement or surgery per Policy Year |
| **Therapeutic termination of pregnancy** | Reasonable Expenses up to $500 Maximum per Policy Year |
| **Routine nursery care of a newborn child of a covered pregnancy** | Reasonable Expenses up to $500 Maximum per Policy Year |
| **Repairs to sound, natural teeth required due to an Injury** | 100% of Reasonable Expenses up to $500 per Policy Year Maximum |
| **Outpatient prescription drugs including oral contraceptives and devices** | 100% of Actual Charge |

**SECTION 2**

**DESCRIPTION OF COVERAGES**

**COVERAGE A – MEDICAL EXPENSES**

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

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

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

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

**1. Physician office visits.**

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

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

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

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

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

a) a minimum of 48 hours of inpatient care following a vaginal delivery; or

b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

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

1. Parental education;

b) Assistance and training in breast or bottle feeding; and

c) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

**2. Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.(Cervical screenings are not subject to the deductible provision).

**3. Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:

a) female Covered Persons are allowed one baseline mammogram;

b) female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.)

**4. Diabetic Supplies/Education:** Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.

**5. Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

**6. Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:

a) Reconstruction of the breast on which the mastectomy has been performed;

b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

c) Prostheses; and

d) Treatment for physical complications of all stages of mastectomy, including lymphedemas.

**SECTION 3**

**COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

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

Loss Benefit

Loss of life 100% of the Principal Sum

Loss of one hand 50% of the Principal Sum

Loss of one foot 50% of the Principal Sum

Loss of sight in one eye 50% of the Principal Sum

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

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

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

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

**SECTION 4**

**COVERAGE C – REPATRIATION OF REMAINS BENEFIT**

If Covered Person dies from a Covered Sickness or Injury,while traveling outside of his/her home country, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

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

**SECTION 5**

**COVERAGE D – MEDICAL EVACUATION BENEFIT**

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

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

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

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

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

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

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

**SECTION 6**

**COVERAGE E – BEDSIDE VISIT BENEFIT**

If a Covered Person is Hospital Confined due to an Injury or Sickness for more than 7 days, is likely to be hospitalized for more than 7 days or is in critical condition, whiletraveling outside of his/her home country,the Insurer will pay up to the maximum benefit as listed in Table 1 of the Schedule of Benefits for the cost of one economy round‑trip air fare ticket to, and the hotel accommodationsin,the place of the Hospital Confinement for one person designated by the Covered Person. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

The determination of whether the Covered Member will be hospitalized for more than 7 daysor is in critical condition shall be made by the Administratorafter consultation with the attending physician. No more than one (1) visit may be made during any 12 month period. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

**SECTION 7**

**LIMITATIONS**

**A. Pre‑Existing Condition Limitation**

The Insurer does pay benefits for loss due to a Pre‑Existing Condition.

**B. Limitation of Maternity Coverage.**

The Policy does not pay benefits for maternity coverage unless conception occurred while the Covered Person was insured under the Policy.

**SECTION 8**

**GENERAL POLICY EXCLUSIONS**

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

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

**SECTION 9**

**DEFINITIONS**

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

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

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

**Alcohol Abuse** means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

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

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;

2. Is primarily engaged in performing surgery on its premises;

3. Has a licensed medical staff, including Physicians and registered nurses;

4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and

5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

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

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

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

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

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

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

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

1. administered or ordered by a Physician;

2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;

3. are not excluded by any provision of the Policy; and incurred while the Covered Person’s insurance is in force under the Policy, except as stated in the Extension of Benefits provision.

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

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

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

**Drug Abuse** means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

**Durable Medical Equipment** means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;

2. Can withstand long term repeated use without replacement;

3. Is not useful in the absence of Injury or Sickness; and

4. Can be used in the home without medical supervision.

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

**Eligible Dependent:** An Eligible Dependent may be the Eligible Participant’s lawful spouse and/or his/her unmarried children under age 19 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term “child/children” includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child’s adoption. The Eligible Dependent is one who

1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and

2. Is temporarily located outside the Eligible Participant’s Home Country as a non‑resident alien; and

3. Has not obtained permanent residency status.

**Eligible Participant** means a person who:

1. Is engaged in international educational activities; and

2. Is temporarily located outside his/her Home Country as a non‑resident alien;and

3. Has not obtained permanent residency status.

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

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

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

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

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

**Hospital** means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;

2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;

3. Provides 24 hours nursing service; and

4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

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

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

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

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

1. Which is reserved for the critically ill requiring close observation; and

2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

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

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

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

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

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

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

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

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

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

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

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

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

**Pre‑Existing Condition** means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received up to one (1) year prior to the Covered Person’s effective date of coverage.

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

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or

2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

**Registered Nurse** means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters “R.N.” or “R. P.N.” after his/her name.

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

**Total Disability or Totally Disabled**

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person’s complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.

2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person’s inability to engage in the normal activities of a person of like age and sex while:

a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or

b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

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

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

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

**SECTION 10**

**EXTENSION OF BENEFITS**

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

**SECTION 11**

**EXCESS COVERAGE**

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

**SECTION 12**

**ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE**

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

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

1. The effective date of his/her insurance; or

2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

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

1. The effective date of the Policy; or

2. The Participating Organization’s or Institution’s Effective Date;

3. The effective date shown on the Insurance Identification Card, if any;

4. The date the requirements in Section 1 – Eligible Classes are met; or

5. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Personis in his/her Home Country. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

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

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

2. The maximum benefit applicable to the covered medical condition under this plan.

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

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

1. The date the Policy terminates;

2. The Participating Organization’s or Institution’s Termination Date;

3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;

4. The end of the term of coverage specified in the Eligible Participant’s enrollment form, if any, including any requested extension;

5. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;

6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or

7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

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

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

**When an Eligible Dependent’s Coverage Starts:** An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, entry into or departure from the Country of Assignment. An Eligible Dependent’s coverage starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or

2. The Participating Organization’s or Institution’s Effective Date;

3. The effective date of the Eligible Participant’s insurance;

4. The effective date shown on the insurance identification card, if any;

5. The date the eligibility requirements in this section are met; or

6. The date the completed enrollment form, if any, and premium are received by the Insurer.

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

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

1. The date the Policy terminates; or

2. The Participating Organization’s or Institution’s Termination Date;

3. The date the Eligible Participant is no longer covered under the Policy;

4. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;

5. 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country;

6. The date the Covered Person requests cancellation of coverage (the request must be in writing);

7. The premium due date for which the required premium has not been paid, or

8. The date on which the dependent ceases to meet the eligibility requirements.

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

**SECTION 13**

**COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN**

**Coverage of Newborn Infants:** A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits.

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

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

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and

2. The required payment of the appropriate premium, if any, must be received by the Insurer.

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

**SECTION 14**

**CLAIM PROVISIONS**

**Notice of Claim:** Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

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

**Proofs of Loss:** Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

**Time for Payment of Claim:** Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

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

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

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

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

**SECTION 15**

**GENERAL PROVISIONS**

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

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

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

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

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

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

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

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

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

**Not in Lieu of Workers’ compensation.** The Policy does not satisfy any requirement for Workers’ Compensation.

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

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

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

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

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

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

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

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

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

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

**HM Life Insurance Company**

**120 Fifth Avenue**

 **Fifth Avenue Place**

**Pittsburgh, PA 15222**

**Dispute Resolution**

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

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

**HM LIFE INSURANCE COMPANY**

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

1-800-328-5433

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

## Endorsement to Certificate

State of Pennsylvania

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 Pennsylvania, as follows:

1. Section 2.C. of the Certificate is amended to include coverage #5 regarding Child Immunizations as Child Immunization coverage is mandatory in Pennsylvania per Pennsylvania statute, 40 P.S. 3501 et seq., and is not subject to any deductible or maximum limit provisions stated in the policy or certificate. Child Immunization coverage includes the cost of the immunization of a child, up to 150% of the AWP of the immunizing agent, if the immunization conforms with ACIP standards in effect on May 21, 1992, governing the issuance of ACIP recommendations for the immunization of children. Those standards are as follows:

(i) The immunization practice is based upon both published and unpublished scientific literature as a means to address the morbidity and mortality of the disease.

(ii) The immunization practice is based upon labeling and packaging inserts for the immunizing agent.

(iii) The immunizing agent is safe and effective.

(iv) The schedule for use of the immunizing agent is administratively feasible.

2. Section 2.C. of the Certificate is amended to include coverages #2 and #3 ascervical cytology screening and mammography screening are mandatory coverages in Pennsylvania per Pennsylvania statute, 40 P.S. 1571 et seq. and 40 P.S. 764c.

3. Exclusion 20 of the Certificate does not apply to cancer chemotherapy and cancer hormone treatments per Pennsylvania statute, 40 P.S. 764b.

4. Section 2.C. of the Certificate is amended to include coverage #6 regarding as coverage for Breast Reconstruction due to Mastectomy as this coverage is mandatory in Pennsylvania per Pennsylvania statute, 40 P.S. 764c.

5. Exclusion 15 of the Certificate does not apply to coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician per Pennsylvania statute, 40 P.S. 3901.

6. Section 2.C. of the Certificate is amended to include coverage #4 for Diabetic Supplies/Education as this coverage is mandatory in Pennsylvania per Pennsylvania statute, 40 P.S. 764e.

1. The Schedule of Benefits and Section 2.C. of the Certificate are amended to include coverage coverage for serious mental illnesses which includes thirty (30) inpatient and sixty (60) outpatient days annually; an insured may convert coverage of inpatient days to outpatient days on a one-for-two basis; treatment for serious mental illnesses should be treated the same as any other illnesses with regard to the annual or lifetime dollar limits.

8. The Schedule of Benefits and Section 2.C. of the Certificate are amended to include coverage for Alcohol Abuse and Dependency Treatment per Pennsylvania Statutes, 40 P.S. § 908-3. This coverage includes the following:

a)  *First instance or course of treatment.* In the first instance or course of treatment for alcohol abuse and dependency, no deductible or copayment may be less favorable than those applied to similar classes or categories of treatment for other conditions of physical illness or injury.

b)  *Second and subsequent courses of treatment.* For the second and subsequent courses of treatment for alcohol abuse and dependency, the total proportion of payment after the deductibles and copayments may not be less than 50% of the allowance for similar classes or categories of treatment for other conditions of physical illness or injury.

c)  Nonhospital, residential alcohol treatment services shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services.

d)  Outpatient alcohol treatment services shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for nonhospital residential alcohol treatment services.

e)  Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 nonhospital, residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b).

f)  Treatment services provided in subsections (a)—(c) are subject to a lifetime limit, for a covered individual, of 90 days of nonhospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits.

9. Per PA Code § 89.406, any Pre-Existing Condition Limitation stated in this policy is hereby deleted.

10. The Certificate is amended to include coverage for colorectal screenings in accordance with the American Cancer Society colorectal cancer screening guidelines. The same deductible and copayment provisions as applicable to other similar coverages in the policy apply to this coverage. This coverage does not apply to small groups (2-50 employees).

11. Effective July 1, 2009, the Certificate is amended to include coverage for the diagnosis and treatment of autism spectrum disorders (ASD) for children and youth under age 21, capped at $36,000 annually without any limits on number of visits to autism service provider for treatment. Coverage is subject to copayment, deductible and coinsurance provisions, and any other general exclusion or limitations to the same extent as other covered medical services under the Certificate. This coverage does not apply to small groups (2-50 employees).

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

 President