

HM LIFE INSURANCE COMPANY OF NEW YORK

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

State University of New York Study Abroad

CERTIFICATE OF COVERAGE

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. HM-1054-09 ("the Policy")

Participating Organization or Institution: State University of New York

Participating Organization's or Institution's Effective Date: August 15, 2009

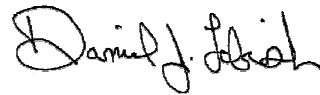
Eligible Participant: See Identification Card Issued to Participant

Eligible Dependents: See Identification Card Issued to Participant

Coverage Start Date: See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a "Covered Person," and to **HM Life Insurance Company of New York** as "Insurer." The Policy will be administered on behalf of the Insurer by "the Administrator," Worldwide Insurance Services, Inc., aka "HTH Worldwide."

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



President

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**SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES**

The Classes eligible for coverages available under the Policy are shown below.

Class I: Regular, full-time Eligible International Participants of the educational organization or institution.

Class II: Voluntary - Eligible Dependents - Spouse.

Class III: Voluntary - Eligible Dependents - Child.

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			
Maximum Benefit per Injury or Sicknesses	\$200,000	\$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

**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 1 LEVELS OF COVERAGE FOR BASIC MEDICAL EXPENSE BENEFITS, SUPPLEMENTAL MAJOR MEDICAL EXPENSE BENEFITS, AND CATASTROPHIC MAJOR MEDICAL EXPENSE BENEFITS; AND
3. TABLE 2 PLAN TYPE LIMITS (INDEMNITY)

MEDICAL EXPENSE	COVERED PERSON
Maternity Care for a Covered Pregnancy	Reasonable Expenses
Inpatient treatment of Mental / Nervous Conditions	Reasonable Expenses for a maximum period of 60 days per Policy Year.
Outpatient treatment of Mental / Nervous Conditions	Reasonable Expenses for a maximum of 30 Visits per Policy Year.
Outpatient Crisis Intervention Services related to treatment of Mental / Nervous Conditions	Reasonable Expenses for up to 3 psychiatric emergency visits per Policy Year. Each visit will reduce the number of visits available under Outpatient Treatment of Mental / Nervous Conditions.
Elective 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 \$1,500 Maximum per Policy Year
Medical treatment arising from participation in intercollegiate or interscholastic sports	Reasonable Expenses up to \$1,500 Maximum per Policy Year
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses
Vaccinations required by Participating Organization or Institution	100% of Reasonable Expenses
Outpatient prescription drugs including prescription contraceptives and devices	100% of Actual Charge
Medical treatment received in the Home Country, if NOT covered by Other Plan	100% of Reasonable Expenses up to \$5,000 lifetime maximum

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES

A. What the Insurer Pays for Covered Medical Expenses: If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit for the Eligible Participant or the Maximum Benefit for an Eligible Dependent stated 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, the Recognized Student Health Center provision and to all other limitations and provisions of the Policy.

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

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the 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. a. Inpatient Hospital Services.

b. Hospital and Physician Outpatient 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 (and anesthesia) 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 services; radiation therapy, chemotherapy and hemodialysis ordered by a Physician, 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.

Inpatient hospital services include:

- (a) the use of operating, recovery and cystoscopic rooms and equipment;
- (b) the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;
- (c) diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes for care in the hospital, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital;
- (d) dressings and plaster casts; and
- (e) supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the Insured Person.

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. A Deductible may apply. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

3. Emergency Hospital Services. Emergency Hospital Services are Emergency Medical Care delivered in a Hospital emergency room as defined in this Policy.

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.

Any Participant or Eligible Dependent, if covered, and qualifies for coverage with no Pre-Existing waiting period as described in Section 4, will have pregnancy treated as any other condition and conception will not have to have occurred while insured under the Plan.

For Eligible Dependents that do not qualify for the Pre-Existing condition waiver, 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 post delivery care must be provided within 24 hours after discharge, or of the time of the mother's request. The post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a) Physical assessment of the Covered mother and newborn child;
- b) Parental education;
- c) Assistance and training in breast or bottle feeding; and
- d) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Post delivery care will not be subject to deductibles, coinsurance or co-payments.

2. **Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.

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

- a) female Covered Persons are allowed one baseline mammogram;
- b) female Covered Persons are allowed a screening mammogram annually.

The frequency requirements will not be applied to a Covered female having a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer.

4. **Prostate screening tests:** Charges for standard diagnostic testing including, but not limited to, a digital rectal exam and a prostate-specific antigen test at any age for men with a history of prostate cancer, and an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

5. **Child Preventive and Primary Care Services:** Preventive and primary care services to a covered Dependent child from birth to 19 years of age. Such services are exempt from the Deductible Amount and the Copayment. Preventive and primary care means: an initial Hospital check-up upon birth and subsequent well child care visits in accordance with the prevailing clinical standards of a national association of pediatric Physicians designated by the Commissioner of Health; and Outpatient services according to the previously described clinical standards, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests ordered at the visit and performed in the Physician's office. Appropriate immunizations are determined by the Insurance Superintendent and consist of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b, and hepatitis b.

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:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage will be provided for such period as is determined by the attending Physician in consultation with the patient to be appropriate for such Covered Person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by this Policy.

7. Outpatient Prescription Drugs: If Outpatient Prescription drugs are provided within the Schedule of Benefits, Table 3, Outpatient Prescription Drugs will include nutritional supplements when required for the Medically Necessary treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria; and Enteral formulas for the Medically Necessary treatment of a Covered Person who is or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases for which enteral formulas constitute Medically Necessary treatment include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment; chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism includes modified solid food products that are low in protein or which contain modified food protein. Enteral formulas do not include nutritional supplements taken electively.

8. Diabetes treatment: Charges for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a Physician or other licensed health care provider legally authorized to prescribe under title eight of the Education Law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, tests strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices and oral agents for controlling blood sugar. The Insurer will also provide coverage for diabetes self-management education to ensure that Covered Persons are educated as to proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits Medically Necessary upon the diagnosis of diabetes, where a Physician diagnoses significant change in the patient's symptoms or condition which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the Physician or other licensed health care provider legally authorized to prescribe under title eight of the Education Law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral of a Physician or other licensed health care provider legally authorized to prescribe under title eight of the Education Law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practical. Coverage for self-management education relating to diet shall also include home visits when Medically Necessary.

9. Chemical abuse and Chemical dependency: Coverage will include expenses incurred for outpatient visits for the diagnosis and treatment of chemical abuse and chemical dependency. Benefits are limited to 60 outpatient visits in any calendar year, of which 20 visits may be for family members. Each family member visit is deducted from the 60 allowable outpatient visits in a calendar year. Coverage for family members include visits for remediation, through counseling and education, of the adverse effects on the physical and mental health of family members resulting from a close relationship with the Covered Person receiving or in need of treatment of alcoholism or alcohol abuse.

As used here, the term chemical abuse includes alcohol and substance abuse and the term chemical dependency includes alcoholism and substance dependence.

10. **Pre-hospital Emergency Medical Services:** Coverage will include expenses incurred for pre hospital Emergency Medical Services (pre-hospital emergency medical services means the prompt evaluation and treatment for an emergency medical condition and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.)
11. **Bone Density Testing:** Coverage will include expenses incurred for bone mineral density measurements or tests, and if the Policy includes coverage for prescription drugs, coverage will also include Medically Necessary prescription drugs or devices for the detection of osteoporosis. Covered Persons qualifying for this coverage include those:
- (i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
 - (ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
 - (iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or
 - (iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
 - (v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Bone mineral density measurements or tests, drugs and devices shall include those covered under the federal Medicare program as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

12. **Second Medical Opinion:** Charges for a second medical opinion by an appropriate specialist, including but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer.
13. **Chiropractic Care:** Charges for chiropractic care provided by a Physician, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
14. **End of Life Care:** Charges incurred by a Covered Person who has a life expectancy of six months or less, as certified by the Covered Person's primary Physician, for hospice or acute care services at a hospice or acute care facility licensed pursuant to article twenty-eight of the public health law specializing in the treatment of terminally ill patients if the patient's attending health care practitioner, in consultation with the medical director of the facility determines that the Covered Person's care would appropriately be provided by such a facility.

End of Life Care at a hospice or acute care facility as defined above is available for 210 days of coverage beginning with the first day on which coverage is provided, for inpatient hospice or acute care in a hospice or Hospital and home care and Outpatient services provided by such facility, including drugs and medical supplies, as well as 5 visits for bereavement counseling services for family members.

If the Insurer disagrees with the admission of or provision or continuation of care for the Covered Person by the facility, the Insurer shall initiate an expedited external appeal in accordance with the provisions of paragraph three of subsection (b) of Insurance Code Section four thousand nine hundred fourteen, provided further, that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by the Insurer and the Insurer shall provide coverage and reimburse the facility for services provided subject to the provisions of this benefit and other limitations otherwise applicable under the Covered Person's contract. The decision of the external appeal agent shall be binding on all parties. If the Insurer does not initiate an expedited external appeal, the Insurer shall reimburse the facility for services provided subject to the provisions of this benefit and other limitations otherwise applicable under the Covered Person's contract.

The Insurer shall provide reimbursement for those services at rates negotiated between the Insurer and the facility. In the absence of agreed upon rates, the Insurer shall pay for acute care at the facility's acute care rate under the Medicare program (Title XVIII of the federal Social Security Act), including the Part A rate for Part A services and the Part B rate for Part B services, and shall pay for alternative level care days at seventy-five percent of the acute care rate, including the Part A rate for Part A services and the Part B rate for Part B services.

15. **Mental / Nervous Conditions:** Coverage will include expenses for the diagnosis and treatment of Mental / Nervous Conditions to the extent shown in the Schedule of Benefits.

As used here, Mental / Nervous Condition means a condition for which medically necessary care may be rendered by an eligible practitioner or approved facility and which, in the opinion of the Insurer, is directed predominantly at treatable behavioral manifestations of a condition that the Insurer determines:

- (i) is a clinically significant behavioral or psychological syndrome, pattern, illness, or disorder, and
- (ii) substantially or materially impairs a Covered Person's ability to function in one or more major life activities; and
- (iii) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

The Mental / Nervous Conditions benefit is provided for no less than 30 days of active treatment per calendar year in a hospital as defined by New York law and no less than 20 visits per calendar year for outpatient care in a facility operated by the office of mental health or certified by the commissioner of mental health. Please refer to your Schedule of Benefits for additional detail. The benefit is also provided for both inpatient and outpatient treatment of such a condition, as well as for partial hospitalization, where two partial hospitalization visits are equal to one inpatient day.

As used here, "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health.

Mental / Nervous Conditions coverage will be provided for adults and children with a biologically based mental illness. As used here, "biologically based mental illness" means a mental, nervous or emotional disorder caused by a biological disorder of the brain which results in clinically significant, psychological syndrome or pattern that substantially limits the functioning of the Covered Person. Biologically based mental illnesses may include schizophrenia and psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, and eating disorders such as bulimia and anorexia.

Coverage will also be provided for a Covered Person who is a child under 18 years of age with serious emotional disturbances. Such emotional disturbances may include a diagnosis of attention deficit disorder, disruptive behavior disorder, or pervasive development disorder, and where there are one or more of the following:

- (i) a serious suicidal symptom or other life-threatening self-destructive behavior;
- (ii) significant psychotic symptoms such as hallucinations, delusion, or bizarre behaviors;
- (iii) behavior caused by emotional disturbances that has placed the child at risk of causing personal injury or significant property damage; or
- (iv) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

D. Home Country Coverage (While Insured): Expenses incurred within the Covered Person's Home Country while insured under the Policy will be considered as Covered Medical Expenses up to the limits stated in the Schedule of Benefits.

The Insurer will not cover any medical expense incurred in the Home Country after the Home Country medical expense coverage limits described above have been exceeded.

Payment is subject to the Limitations and Conditions on Eligibility for Benefits provision.

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 unless Home Country coverage has been purchased as shown in Table 3.

SECTION 4 PRE-EXISTING CONDITION LIMITATION

For the Participant: The Insurer does pay benefits for loss due to a Pre-Existing Condition while the Covered Person is continuously insured during the first 6 months of coverage.

For the Spouse/Dependent: The Insurer does not pay benefits for loss due to a Pre-Existing Condition while the Covered Person is continuously insured during the first 6 months of coverage, unless a Written request for dependent coverage is submitted within 30 days following the date on which he or she first becomes eligible for coverage starting on the Eligible Participant's effective date of coverage. Pre-Existing Conditions will be covered after the Covered Person's coverage has been in force for 6 months however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Policy. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.

After the Covered Person has been Continuously Insured under the Policy for the time period described in the paragraph above, Pre-Existing Conditions will be covered the same as any other Injury or Sickness.

However, the Insurer will allow a credit for the time a Covered Person was covered by Creditable Coverage that was in effect not more than 63 days before the Covered Person's effective date under the Policy. As used here, Creditable Coverage means coverage provided under:

- a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 101 et seq.);
- b) a group health benefit plan provided by a health insurance carrier or health maintenance organization;
- c) an individual health insurance policy or evidence of coverage;
- d) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
- e) Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);
- f) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
- g) A medical program of the Indian Health Service or of a tribal organization;
- h) A state or political subdivision health benefits risk pool;
- i) A health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);
- j) A public health plan as defined by federal regulations;
- k) A health benefit plan under Section 5 (e), Peace Corps Act (22 U.S.C. Section 2504(e)).

This Pre-Existing Condition limitation does not apply to (1) an individual who, as the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; (2) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage; or (3) an individual, and any dependent of such individual, who is eligible for a federal tax credit under the Federal Trade Adjustment Assistance Reform Act of 2002 and has three months or more of creditable coverage.

SECTION 5 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. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment. This exclusion does not apply to a congenital condition or anomaly of an Eligible Participant's child insured under the Policy that resulted from a functional defect.
2. Participating in a felony.
3. 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.)
4. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction that is dental in nature or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, unless they result directly from an Injury which necessitated medical treatment. This exclusion does not apply to treatment due to a congenital condition or anomaly.
5. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; or riot.
6. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
7. Expenses incurred as a result of pregnancy that is not covered.
8. 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.
9. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician.

SECTION 6 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, unless the Covered Person has been continuously insured as stated in the Pre-Existing Condition Limitation.

Age means the Covered Person's attained age.

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

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

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

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

Confinement (Confined) means the 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.

Continuously Insured means the Covered Person has been insured continuously under the Policy or prior Creditable Coverage without a break of more than 63 days.

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.

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 22 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 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 results from a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

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

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

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 short-term, acute, general hospital, which: (1) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; (2) has organized departments of medicine and major surgery; (3) has a requirement that every patient must be under the care of a physician or dentist; (4) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (5) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]); (6) is duly licensed by the agency responsible for licensing such hospitals; and (7) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

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 unless the Covered Person has been Continuously Insured as stated in the Pre-Existing Condition Limitation. 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 Necessary means medical and dental service, treatment or supplies which are:

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

A medical or dental treatment will not be deemed Medically Necessary if the Insurer determines that any service, supply or treatment used or provided in connection with the Injury or Sickness is Experimental or Investigational in nature, unless an external appeals agent has determined, upon review, that the treatment for the Covered Person was not Experimental or Investigational.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary. If services do not meet the criteria above or are not consistent with professionally recognized standards of care with respect to quality, frequency or duration, such services will not be deemed Medically Necessary.

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

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

Out-of-Pocket Limit means the amount of Reasonable Expenses which the Covered Person must pay after which the Insurer pays 100% of the reasonable Expenses, subject to the limits and provisions of the Policy.

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

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

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

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

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

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received up to 6 months prior to the Covered Person's effective date of coverage. However, a Congenital Condition of an Eligible Participant's child who is insured under the Policy is not considered to be a Pre-Existing Condition. The Insurer will not take into consideration any genetic information in the absence of a diagnosis of a condition related to such information in making a Pre-Existing Condition determination.

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

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students for a minimum of 10 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider and is approved as a Recognized Student Health Center by the Administrator.

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, unless the Covered Person has been Continuously Insured as stated in the Pre-Existing Condition Limitation. Pregnancy is considered a sickness.

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 7 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.

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

1. Is Totally Disabled on the date coverage ends;

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

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

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

1. The 90th day following termination of the Policy; or
2. The date the Total Disability ends.

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

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

SECTION 8 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. 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 Participant requests cancellation of coverage (the request must be in writing); or
6. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

If an unmarried insured Eligible Dependent child is:

1. Incapable of self-support due to mental illness; developmental disability; mental retardation as defined in the mental hygiene law of New York; or physical handicap; and
2. Dependent upon the Eligible Participant for support and maintenance;

his insurance will not be terminated because of age. We will require due proof of the child's incapacity within 31 days after he reaches the termination age for children.

The Insurance for the child may be continued for as long as:

1. The incapacity and dependency continues; and
2. The Eligible Participant's insurance remains in force.

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 a.m. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

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

1. The effective date of the Policy; or
2. The effective date shown on the insurance identification card, if any;
3. The date the completed enrollment form, if any, and premium are received by the Insurer.

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

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

1. The date the Policy terminates; or
2. The Participating Organization's or Institution's Termination Date;
3. The date the Eligible Participant is no longer covered under the Policy;
4. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;
5. 11:59:59 a.m. on the date he or she, if a dependent of an International Student Eligible Participant's or a Study Abroad Student Eligible Participant, 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 a.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.

SECTION 9 COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

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

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of 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.

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

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

In order to continue the coverage of a newborn child beyond the 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 10 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 end of a period for which we are liable. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer are liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided it was not reasonably possible to provide proof in that time.

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately, but not later than 60 days, 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 \$500 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

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

Notice of Grievance Procedures to New York Residents

If a Covered Person has any question about any decision related to their coverage with the Insurer, the Covered Person may call the Insurer at the 800# provided on their Identification Card and a Customer Service Representative will assist such Covered Person.

If a claim is denied in whole or in part, the Covered Person, the Covered Person's attending physician or Covered Person's personal representative acting on the Covered Person's behalf, may file a complaint/grievance either orally (by telephone or in person) or in writing (by mail or electronic means). If it is an oral complaint, the Covered Person will expect a confirmation letter from the Insurer with a request for the Covered Person to complete an acknowledgment form and mail it back to the Insurer. This acknowledgment receipt will initiate the complaint.

A written complaint submitted by the Covered Person or on the Covered Person's behalf about a decision rendered on the basis that the health benefit plan contains a benefit exclusion for the health care services in question or that the benefits have been exhausted, is not a grievance if the exclusion of the specific service requested and the maximum benefit limits are clearly stated in this Certificate of Coverage. The Covered Person's written request should contain all of the issues and comments which are pertinent and should be sent to:

**HM Life Insurance Company of New York
care of HTH/Worldwide Insurance Services
One Radnor Corporate Center, Suite 100
Radnor, PA 19087**

All grievance procedures are voluntary and at any time the Covered Person may seek the assistance of the Commissioner of Insurance at the following address:

**Commissioner of Insurance
One Commerce Plaza
Albany, NY 12257
Telephone: 518-474-6600**

Within 10 working days after receipt of the Covered Person's written request, the Covered Person will receive a letter from Us confirming the receipt of their complaint/grievance and informing them of the name, address and telephone number of the designated person who will be reviewing their complaint/grievance. If all the information received is complete, the Covered Person's complaint/grievance will be decided within 30 days after receipt of their request. If additional information necessary for a review is requested, the Covered Person will receive a status letter informing them of the reason(s) for the delay. The Covered Person's complaint/grievance will be decided within 30 days after receipt of all requested information.

The Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, will be immediately notified of the determination no later than 3 business days of the resolution.

If the Covered Person is not satisfied with the decision, the Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, may file an appeal as follows:

First Level Internal Review: The Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, may file a written request for first level review within 45 days after the date of receipt of notice of an adverse determination. At this level, the request will be reviewed by a qualified individual knowledgeable with the matters at issue and at a higher level position than the person who made the initial adverse determination.

Second Level Internal Review: The Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, may file a written request for a second level review within 45 days after the date of receipt of notice of first level review. At this level, the request will be reviewed by a qualified individual knowledgeable with the matters at issue and at a higher level position than the person who made the first level review determination.

If the appeal refers to clinical matters, it will be immediately referred to an external review agency, preferably one designated by the state, if any. All appeals will be acknowledged by the Insurer in writing within 10 business days of its receipt. The review and resolution at all levels will be completed within 30 business days of the receipt of the written request except in cases where additional information is requested or the time is waived or extended by mutual agreement. If additional information necessary to complete the review is requested, the Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, will be notified in writing immediately of the status of the appeal. All attempts will be made to notify the Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, immediately either by telephone or facsimile of the results of the review but no later than 3 business days of the determination.

If the services have not yet been performed, and the Covered Person's attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Covered Person's health, the Covered Person may request an Expedited External Review. The Covered Person may however, be required to provide documentation of the medical justification for the review. In this case, the Covered Person will be notified of the decision as soon as possible by telephone or facsimile, but not later than 48 hours after receiving the information justifying the expedited review. The Covered Person will also be notified of the decision in writing.

Independent External Review

Under certain circumstances, the Covered Person have a right to an External appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, the Covered Person, the Covered Person's medical provider or the Covered Person's personal representative may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

If the Plan has denied coverage on the basis that the service is not medically necessary, the Covered Person may appeal to an External Appeal Agent if they satisfy the following criteria:

- The service, procedure or treatment must otherwise be a Covered Service under this Policy; and
- The Covered Person must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or the Covered Person and the Plan must agree in writing to waive any internal appeal.

If the Covered Person has been denied coverage on the basis that the service is an experimental or investigational treatment, the Covered Person must satisfy the following criteria:

- The service must otherwise be a Covered Service under this Policy; and
- The Covered Person must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or the Covered Person and the Plan must agree in writing to waive any internal appeal.

In addition, the Covered Person's attending physician must certify that the Covered Person has a life-threatening or disabling condition or disease and that such is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard of service or procedure covered by the Plan or one for which there exists a clinical trial as defined by law.

In addition, the Covered Person's attending physician must have recommended one of the following:

- A service, procedure or treatment that 2 documents from available medical and scientific evidence indicate is likely to be more beneficial to the Covered Person than any standard Covered Service (only certain documents will be considered in support of this recommendation – the Covered Person's attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which the Covered Person is eligible (only certain clinical trials can be considered).

A "life-threatening condition or disease" is one, which, according to current diagnosis of the Covered Person's attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders the Covered Person unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The Covered Person's attending physician must be a licensed, board certified or board eligible physician qualified to practice in the area appropriate to treat Covered Person's life-threatening or disabling condition or disease.

If through the Plan's internal appeals process, the Covered Person has received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, or if the Covered Person and the Plan have agreed in writing to waive any internal appeal, it is the Covered Person's responsibility to initiate the external appeals process.

Under NY State law, the Covered Person's completed request for appeal must be filed within 45 days of either receipt of such notice of adverse determination or waiver to file a written request for an external appeal. The Plan has no authority to grant an extension of this deadline.

In either case, the Plan will provide an external appeal application with the final adverse determination issued through the Plan's internal appeal process or its written waiver of an internal appeal. The Covered Person may also request an external appeal application directly from the New York State at [\(518\) 474-6600](tel:5184746600).

The Covered Person may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to the Covered Person, the Covered Person's attending physician may file an external appeal application on the Covered Person's behalf, but only if the Covered Person has consented to it in writing. If the Covered Person satisfied the criteria for an external appeal, the State will forward the request to a certified External Appeal agent.

The Covered Person will have an opportunity to submit additional documentation with their request. If the external appeal agent determines that the information the Covered Person submits represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have 3 business days to amend or confirm its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of the Covered Person's completed application. The external appeal agent may request additional information from the Covered Person, the Covered Person's physician or the Plan. If the external appeal agent requests additional information, it will have 5 additional business days to make its decision. The external appeal agent must notify the Covered Person in writing of its decision within 2 business days.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to other terms and condition of this Policy. Please note that, if the external appeal agent approves coverage of an experimental or investigational treatment that is a part of a clinical trial, the Plan will only cover the costs of services required to provide the treatment to the Covered Person according to the designs of the trial. The Plan shall not be responsible for costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research or costs which would not be covered under this Policy for non-experimental or non-investigational treatments provided in such clinical trials. The external appeal agent's decision is binding on both the Covered Person and the Plan and is admissible in any court proceeding.

SECTION 11 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: Third Party means a person or organization other than the Covered Person who suffers loss.

When benefits are paid to or for a Covered Person under the terms of the policy, the Insurer shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Covered Person, for hospital, medical or surgical services and benefits. The right of subrogation will only be exercised by the Insurer when the amounts (or portion) received by the Covered Person through a Third Party settlement or satisfied judgment is specifically identified as amounts paid for hospital, medical or surgical services and benefits. Such subrogation rights shall extend only to the recovery by the Insurer of the benefits the Insurer has paid for such hospitalization and treatment.

This provision does not apply to any amount received under any other insurance policy or certificate issued to and in the name of the Covered Person.

This provision does not apply with respect to the Medical Evacuation Benefit and the Repatriation of Remains Benefit.

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.

HM LIFE INSURANCE COMPANY OF NEW YORK

420 Fifth Avenue, Third Floor, New York, New York, 10018
1-800-328-5433

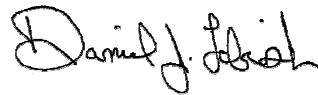
Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Contraceptive Drug Benefit Rider

This rider is made a part of the Policy to which it is attached. It amends the Policy, and the Certificates of Insurance issued pursuant to that Policy, as stated below.

If outpatient prescription drugs are covered, also included are the charges for contraceptive drugs or devices approved by the Federal Food and Drug Administration ("FDA") or generic equivalents approved as substitutes by the FDA under the prescription of a Physician legally authorized to prescribe under title eight of the education law. This benefit is provided whether such contraceptive drugs or devices are received as part of an office visit or at a pharmacy.

This rider takes effect and expires at the same time as the Policy/Certificate of Insurance to which it is attached.



President