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The Research Foundation for SUNY
Blue Cross Blue Shield Global Traveler
Supplemental Blanket Travel Plan

Policy Holder: The Research Foundation for SUNY
Certificate of Coverage: 4EL-7035-24
Effective Date: January 1, 2024

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

The Insurance Coverage Area is any place that is outside the United States.


PRESIDENT


SECRETARY

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The insurance evidenced by this Certificate provides limited benefit sickness and accident insurance during business travel. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York Department of Financial Services.

I. Introduction

About This Plan

This Certificate of Coverage is issued by 4 Ever Life Insurance Company (“Insurer”) through a policy issued to Policyholder.

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

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

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

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

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

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

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

Typically, when accessing care inside the United States, Puerto Rico, and the United States Virgin Islands, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). In some instances, you may obtain care from providers that do not contract with the Host Blue (non-participating healthcare providers). Worldwide Insurance Services payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Worldwide Insurance Services will remain responsible for fulfilling Worldwide Insurance Services contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Worldwide Insurance Services.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Worldwide Insurance Services uses for your claim because they will not be applied retroactively to claims already paid.

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

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

1. Member Liability Calculation

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

2. Exceptions

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

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

Benefit Overview Matrix

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

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

Deductible:

The Insured Person's Deductible is \$0 per Insured Person per Trip Coverage Period.

Copayment:

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

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

BENEFIT OVERVIEW MATRIX

Policy Maximums	Insurer pays up to Per Insured Person
Trip Period Maximum Benefits	\$200,000
Period of Insurance Maximum Benefits	\$200,000
Benefits	Insurer pays
Professional Services	
a. Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab	100%
b. Office Visits: including X-rays and lab work billed by the attending physician.	100%
Inpatient Hospital Services	
a. Surgery, X-rays, In-hospital doctor visits	100%
b. In-patient medical emergency	100%
Ambulatory Surgical Center	100%
Ambulance Service (non Medical Evacuation)	100% up to \$1,000
Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor)	Limited to Trip Period Maximum or \$10,000 whichever is less.
Outside Home Country Outpatient prescription drugs	100% of Covered Expenses
Dental Care required due to an Injury	100% of Covered Expenses up to \$200 with maximum per Trip Period
Dental Care for Relief of Pain	100% of Covered Expenses up to \$100 per Trip Period
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to \$10,000 for Eligible Participant; Principal Sum up to \$10,000 for Eligible Dependent.
Repatriation Of Remains	Deductible is not applicable. Maximum Benefit up to \$50,000.
Medical Evacuation	Deductible is not applicable. Maximum Benefit per Trip Period for all Evacuations up to \$250,000.
Bedside Visit	Deductible is not applicable. Maximum Benefit per Trip Period up to \$1,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person.

II. Who is eligible for coverage?

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

Who is Eligible to Enroll Under This Plan?

An Eligible Participant:

1. Is an employee of a Group covered under the Policy and
2. Has submitted an enrollment form, if applicable, and the premium to the Insurer.

Eligible Dependents

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

1. spouse; partner;
2. unmarried natural child, stepchild or legally adopted child **through age 29**;
3. own or spouse's own unmarried child, of any age, enrolled prior to age 29, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, as defined in the mental hygiene law or physical handicap and who became so incapable prior to attainment of the age at which coverage would otherwise terminate and who is chiefly dependent upon the employee for support and maintenance, while the insurance of the employee remains in force and the child remains in such condition. The insured employee has thirty-one days from the date of the child's attainment of the termination age to submit proof of the child's incapacity and annually thereafter;
4. For a person who becomes an Eligible Dependent (as described below) after the date the Eligible Participant's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:
 - a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
 - b. Adopted Children: An adopted child of the Insured 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 and during any waiting period prior to the finalization of the child's adoption. Coverage terminates if the placement is disrupted and the child is removed from placement. To continue coverage beyond 31 days, an Insured Participant must enroll the adopted child within 31 days either from the date of placement or the final decree of adoption.
 - c. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is spouse or minor child, coverage will be automatic for the first 31 days following the date which the court order is issued. To continue coverage beyond 31 days, and Insured Participant must enroll the Eligible Dependent within that 31 day period ;
5. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

As used above:

1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued or the marriages of same-sex couples legally performed in other jurisdictions. This term includes a common law spouse if allowed by the State where the Policy is issued.
3. The term "partner" means an Eligible Participant's spouse or domestic partner.
4. Proof of the domestic partnership and financial interdependence must be submitted to us in the form of:
 - A. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
 - B. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 1. The affidavit must be notarized and must contain the following:
 - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
 - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
 - The partners have been living together on a continuous basis prior to the date of the application; and
 2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

3. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
 - a. A joint bank account
 - b. A joint credit card or charge card
 - c. Joint obligation on a loan
 - d. Status as an authorized signatory on the partner's bank account, credit card or charge card
 - e. Joint ownership of holdings or investments
 - f. Joint ownership of residence
 - g. Joint ownership of real estate other than residence
 - h. Listing of both partners as tenants on the lease of the shared residence
 - i. Shared rental payments of residence (need not be shared 50/50)
 - j. Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
 - k. A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
 - l. Shared household budget for purposes of receiving government benefits
 - m. Status of one as representative payee for the other's government benefits
 - n. Joint ownership of major items of personal property (e.g., appliances, furniture)
 - o. Joint ownership of a motor vehicle
 - p. Joint responsibility for child care (e.g., school documents, guardianship)
 - q. Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
 - r. Execution of wills naming each other as executor and/or beneficiary
 - s. Designation as beneficiary under the other's life insurance policy
 - t. Designation as beneficiary under the other's retirement benefits account
 - u. Mutual grant of durable power of attorney
 - v. Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
 - w. Affidavit by creditor or other individual able to testify to partners' financial interdependence
 - x. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

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

1. under Age 85.
2. enrolled in a Primary Plan.
3. Eligible Dependents must be traveling with the Eligible Participant.

Application and Effective Dates

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

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

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

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

1. For a scheduled business trip or sojourn to a Foreign Country, when the Insured Person boards a conveyance at the start of the trip.

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

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

How Period of Insurance Coverage Ends

Insured Persons

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

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

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

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

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

Maximum Trip Coverage Period: Coverage for any one trip may not exceed 180 days.

Group and Insurer

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

The Policy may be terminated by the Insurer:

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

Extension of Benefits

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

III. Definitions

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

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

Age means the Insured Person's attained age.

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

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

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

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

A **Continuing Hospital Confinement** means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occur within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided under the policy to a maximum of 180 days, or, as an alternative with respect to group insurance, successive confinements due to the same or related causes unless between such confinements a covered person has been actively at work, if an employee, or engaged in normal activity if not an employee, for a period of not more than 90 days. A confinement for an accident shall not be combined with another confinement for an illness in determining continuous hospital confinement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Employee means a permanent full time employee or trainee, who usually works at least 40 hours a week in the conduct of the Group's business. Sole proprietors and partners are also eligible if they are actively engaged on a full-time basis. An Employee does not include an employee who works on a part-time, temporary, or substitute basis. An Employee may be a consultant or contractor engaged by the Group in the conduct of its business and works in the conduct of the Group's business at least 40 hours a week. An Employee also includes officers and directors of the Policy Holder regardless of the number of hours a week devoted to the conduct of the Policy Holder's business.

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

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

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

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

Group Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

The term does not include:

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

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

A **Hospital** 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.

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

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

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

Injury (See Accidental Injury)

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

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

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

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

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

Investigative Procedures (See Experimental/Investigational).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

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

Totally Disabled or Total Disability means:

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

The patient must be under the care of a Physician.

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

U.S. means the United States of America.

IV. How the Plan Works

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

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

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

Benefits

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

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

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

Hospitals, Physicians, and Other Providers

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

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

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

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

Deductibles

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

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

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

Period of Insurance Deductible

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

Copayments

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

Out-of-Pocket Maximums

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

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

Plan Payment

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

Limited Benefits

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

1. For Ambulance Service (non Medical Evacuation), 100% up to \$1,000;
2. Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor) that are Limited to the Trip Period Maximum or \$10,000 whichever is less;
3. Outside Home Country for Outpatient prescription drugs 100% of Reasonable Charges for Covered Expenses;
4. Dental Care required due to an Injury, 100% of Covered Expenses up to \$200 with maximum per Trip Period;
5. Dental Care for Relief of Pain, 100% of Covered Expenses up to \$100 per Trip Period.

For all other Covered Expenses

First Level Payment

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

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

Period of Insurance Maximum Benefits

The combined total of all medical benefits paid to the Insured Person is limited to a maximum of \$200,000 during each Insured Person's Period of Insurance, so long as the Insured Participant or the Insured Dependent remains insured under this Plan.

Trip Coverage Period Maximum Benefits

The combined total of all medical benefits paid to the Insured Person is limited to a maximum of \$200,000 during each Trip Coverage Period for each Insured Person, so long as the Insured Participant or the Insured Dependent remains insured under this Plan and so long as the cumulative amount of paid benefits for all Trip Coverage Periods within the Period of Insurance does not exceed the Period of Insurance Maximum.

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

V. Benefits: What the Plan Pays

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

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

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

Services and Supplies Provided by a Hospital

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

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

Payment of Inpatient Covered Expenses are subject to these conditions:

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

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

Professional and Other Services

The Insurer will pay Covered Expenses for:

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

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

Ambulance Services

The following ambulance services are covered under this Plan:

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

Dental Care for an Accidental Injury

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

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

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

Dental Care for Relief of Pain

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

Complications of Pregnancy

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

Physical and/or Occupational Therapy/Medicine

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

Treatment received from Foreign Country Providers

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

Benefits for Claims resulting from downhill skiing and scuba diving

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

Accidental Death & Dismemberment Benefit

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

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 Insured Person due to any one Accident.

The Principal Sum is stated in Benefit Overview Matrix.

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

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

Repatriation of Remains Benefit

If an Insured Person dies, 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 Insured Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Insured Person's Confinement ends or 31 days after the Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

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

Medical Evacuation Benefit

If an Insured Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical service, 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 Insured Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services. Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Insured Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

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

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

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

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

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

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

Bedside Visit Benefit

If an Insured Person is Hospital Confined due to an Injury or Sickness for more than 7 days, is likely to be hospitalized for more than 7 days or is in critical condition, while traveling 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 and hotel accommodations in, the place of the Hospital Confinement for one person designated by the Insured Person. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

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

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

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

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

Excluded Services

The Plan does not provide any benefits for:

1. Mental or emotional disorders, alcoholism and drug addiction, except as specifically covered;
2. Pregnancy, except for complications of pregnancy as defined;
3. Illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto;
4. Suicide, attempted suicide or intentionally self-inflicted injury;
5. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
6. Inter-scholastic sports;
7. Cosmetic surgery, except that *cosmetic surgery* shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
8. Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
9. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference resulting or related to distortion, misalignment or subluxation of or in the vertebral column;
10. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made;
11. Dental care or treatment, except for care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
12. Eyeglasses, hearing aids, and examination for the purpose of prescription or fittings;
13. Rest cures, custodial care and transportation;
14. Any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation; and
15. Any loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

VII. Prescription Drug Benefits

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

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

Conditions of Service

The Drug or medicine must be:

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

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

The Prescription must not exceed a 30-day supply.

Prescription Drug Exclusions and Limitations

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

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

Exception to Exclusions and Limitations for certain Cancer Drug treatment

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

VIII. General Provisions

Third Party Liability

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

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

Benefits for Medicare Eligible Insured Persons

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

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

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

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

Alternate Cost Containment Provision

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

Terms of the Insured Participant's Plan

1. **Entire Contract and Changes:** The entire contract between the Group and the Insurer is as stated in the Policy and the entire contract between the Insured Participant and the Insurer is as stated in the Certificate of Coverage including the endorsements, application, if any, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of the Insurer's officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.
2. **Payment of Premiums:** Premiums are payable in advance. Premiums must be paid monthly including any contributions the Insured Participant must make. The Insurer may change the premium rates from time to time. The Insurer must give the Group written notice of any premium rate change at least 30 days prior to the change. The Insurer may not increase premiums without first providing written notification to the Group at least 30 days prior to the date the increase is to take effect, with the exception of retroactive premium rate increases related to fraud or the intentional misrepresentation of a material fact.
3. **Grace Period:** There is a Grace Period of 31 days allowed for the payment of each premium after the first premium.
4. **Representations:** All statements made by the Insured Participant or the Group shall be considered representations and not warranties. The Insurer must provide the Insured Participant or the Group with a copy of any statements used to contest coverage. 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.

5. **Time Limit on Certain Defenses/Misstatements on the Application:** After two years from the Effective Date of the Policy, the Insurer will not contest the validity of the Policy. After two years from the Insured Participant's Effective Date of Coverage, no misstatements on the Eligible Participant's application may be used to:
- void this coverage, or
 - deny any claim for loss incurred or disability that starts after the 2 year period.

The above does not apply to fraudulent misstatements.

6. **Legal Actions:** The Insured Person cannot file a lawsuit before 60 days after the Insurer has been given written proof of loss. No action can be brought after 2 years from the time that proof is required to be given.
7. **Conformity with State Statutes:** If any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Policyholder resides, it is amended to conform to the minimum requirements of those statutes.
8. **Provision in Event of Partial Invalidity:** If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

9. The Claims Process

Notice of Claim: Within 20 days after an Insured Person receives Covered Services, or as soon as reasonably possible, he/she or someone on his/her behalf, must notify the Insurer in writing of the claim.

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

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

Proof of Loss: Within 120 days after the Insured Person receives Covered Services, he/she must send the Insurer written proof of loss. If it is not reasonably possible to give the Insurer written proof in the time required, the Insurer will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to the Insurer no later than one year from the date otherwise required.

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

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

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

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

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

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

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

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

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

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

The Insurer's right to examine any records exists:

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

Effect on the Benefits of this Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether an overpayment has been recorded for the Covered Person; and
3. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is an overpayment, the Secondary Plan will use the Covered Person's overpayment to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the overpayment amount returns to zero, so that no overpayment is made at the end of the claim determination period.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Grievance Procedures

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:

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

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

Department of Financial Services
One Commerce Plaza
Albany, NY 12257
Telephone: 518-474-6600

Within 15 business days of receipt of the grievance, the Insurer will provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the Insurer to respond to the grievance. All grievances will be resolved in an expeditious manner and in any event, no more than:

1. 48 hours after the receipt of all necessary information when a delay would significantly increase the risk to the Covered Person's health;
2. 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and
3. 45 days after the receipt of all necessary information in all other instances.

The notice of a determination of the grievance will be made in writing to the Covered Person or to the Covered Person's designee. In the case of a determination made in conformance with subparagraph (1), above, notice shall be made by telephone directly to the Covered Person with written notice to follow within 3 business days. The notice of determination will include:

1. The detailed reasons for the determination;
2. In cases where the determination has a clinical basis, the clinical rationale for the determination; and
3. The procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.

The Covered Person or their designee shall not have less than 60 business days after the receipt of the notice of the grievance determination to file a written appeal, which may be submitted by letter or by a form supplied by Us.

Within 15 business days of receipt of the appeal, We will provide written acknowledgement of the appeal, including the name, address and telephone number of the individual or department designated by the Insurer to respond to the appeal and what additional information, if any, must be provided in order for Us to render a decision.

The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined by law. The determination of an appeal on a matter which is not clinical will be made by qualified personnel at a higher level than the personnel who made the grievance determination.

We will seek to resolve all appeals in the most expeditious manner and make a determination and provide notice no more than:

1. 2 business days after the receipt of all necessary information when a delay would significantly increase the risk of a Covered Person's health; and
2. 30 business days after the receipt of all necessary information in all other instances.

The notice of determination on an appeal will include:

1. The detailed reasons for the determination; and
2. In cases where the determination has a clinical basis, the clinical rationale for the determination.

Appeals

Notice of Adverse Determination: A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for Our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will also advise You of Your right to appeal our determination, give instructions for requesting an internal appeal and initiating an external appeal. The notice will specify that You may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for Us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

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 30 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. We will decide all internal appeals related to retrospective reviews within 30 calendar days of receipt of the appeal request.

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. We will decide all internal appeals related to retrospective reviews within 30 calendar days of receipt of the appeal request.

If you are not satisfied with the resolution of your appeal, you may file an External Appeal.

External Review

Your Right to an External Appeal

Under certain circumstances, the Covered Person has 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 (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), 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.

Your Right to Appeal a Determination that a service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal or you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal or the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

The service must otherwise be a Covered Service under this Subscriber Contract; and

You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal or you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal or the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

A clinical trial for which you are eligible (only certain clinical trials can be considered); or

A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS OUT-OF-NETWORK

If the Plan has denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an external appeal agent if you satisfy the following three (3) criteria:

The service must otherwise be a Covered Service under this Subscriber Contract;

You must have requested pre-authorization for the out-of-network treatment; and

You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external appeal for a denial of a to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

THE EXTERNAL APPEAL PROCESS

If, through the first level of the Plan's internal appeal process, you have 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 is an out-of-network treatment you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit 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 three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

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

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

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 or an out-of-network treatment the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the 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 subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

The Plan will charge you a fee of \$25 for each external appeal, not to exceed \$75 in a single plan year. The external appeal application will instruct you on the manner in which you must submit the fee. The Plan will also waive the fee if the Plan determines that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

YOUR RESPONSIBILITIES

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.