DelAmLife

DELAWARE AMERICAN LIFE INSURANCE COMPANY
ONE ALICO PLAZA
WILMINGTON, DELAWARE 19801
(302) 661-8674
(Herein called the Insurance Company)

CERTIFICATE OF INSURANCE
for certain Employees of:

Association of Universities for Research in Astronomy (AURA)
(a Participating Employer effective January 1, 2015)

who are insured under Group Policy Number 3894
issued to

Delaware American Expatriate Group Insurance Trust
(the Policyholder)

Delaware American Life Insurance Company hereby certifies that certain benefits provided by the Group Policy are available to Employees of the Participating Employer who are in an Eligible Class. Under no circumstances may any insurance become effective prior to the Effective Date as determined in the section of this document entitled Effective Date of Insurance.

INTRODUCTION

ABOUT THIS CERTIFICATE. This Certificate describes group medical, vision and dental insurance the Insurance Company provides to Insured Persons under the Group Policy (herein called "the Policy") issued to the Participating Employer.

This document describes the coverage available under the Policy. It becomes an Employee's Certificate of Insurance only after he or she has met the eligibility requirements set forth in the section of this document entitled Eligibility for Insurance.

The coverage is funded through a Group Policy issued to the Policyholder by Delaware American Life Insurance Company.

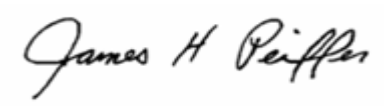
The terms of the Policy that affect your insurance are contained in the following pages.

This Certificate of Insurance and the following pages will become your Certificate. This Certificate is a part of the Policy.

This Certificate replaces any other that the Insurance Company may have issued to the Participating Employer to give to you under the Policy specified herein.

Certain benefits, terms, conditions, limitations, and exclusions in your Certificate have been amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

The President and Secretary of Delaware American Life Insurance Company witness this Certificate:



President

Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

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SCHEDULE OF BENEFITS

Eligible Employees:…… All active, full-time Employees of the Employer who normally work at least 20 hours per week, and are on assignment outside of their country of primary residence and not working in the U.S.

Note: This plan covers only Employees and their Dependents. Any Employee who returns to the U.S.A. or country of primary residence for more than 90 continuous days will be terminated under the plan.

Waiting Period
Existing Employees..... None

Open Enrollment Period: November 3rd through November 21st
Open Enrollment Effective Date: January 1st of each succeeding year

MEDICAL BENEFITS

Classification

All Eligible Employees and their Dependents

Preferred Provider Network

The Preferred Provided Network is an arrangement in which a network of Hospitals and Physicians have agreed to provide medical care services to Insured Persons. The Preferred Provided Network is for expenses incurred in the U.S.A. only. The Hospitals and Physicians will provide these services according to negotiated fee schedules that are considered full payment for services rendered subject to the plan provisions. An Insured Person has the option to utilize an In-Network or an Out-of-Network provider. Benefits applicable to both types of providers are shown below.

For treatment or care received outside any In-Network geographic service area, benefits for Covered Medical Expenses will be payable at Out-of-Network levels. **However, if treatment is received in an Out-of-Network facility on an involuntary basis (such as loss of consciousness as a result of an Emergency Medical Condition), benefits for Covered Medical Expenses will be payable at In-Network levels.**

For treatment or care received for which there is no contracted In-Network provider, benefits for Covered Medical Expenses will be provided at the In-Network level.

For treatment or care rendered by a radiologist, anesthesiologist or pathologist, the applicable percentage payable will be based on the facility in which the care is received.

The Insurance Company is not engaged in rendering medical advice or treatment to any insured patient. The diagnosis, treatment, therapy or medical attention provided to any insured patient represents the healthcare provider's own professional opinion and does not represent or constitute any healthcare advice from the Insurance Company nor any of its' employees or agents. Neither the Insurance Company nor any of its' employees or agents can be held liable for any claim, demand, action costs or charges arising, incurred or sustained as a result of the healthcare providers' diagnosis, treatment or therapy provided.

Preventive Health Benefits

The following preventive health benefits are required to be provided in your Plan

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

MEDICAL BENEFITS **(continued)**

Your Policy provides additional coverage for selected preventive services without a copayment, coinsurance or deductible when these services are delivered by a network provider. Depending upon your age, services may include:

- Screening and tests for diseases
- Mental Health Screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific communities and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at admin.metlifeexpat@alico.com or +1-302-661-8674, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive service, please visit healthcare.gov.

Medical Deductibles

Individual Medical Deductible Per Insured Person

In-Network U.S.	**Out-of-Network U.S.**	**Outside-the-U.S.**
$100	$100	$100

Family Medical Deductible

In-Network U.S.	**Out-of-Network U.S.**	**Outside-the-U.S.**
$200	$200	$200

NOTES:

1. Charges used to satisfy Deductibles for Covered Medical Expenses incurred in the U.S.A. will be credited to the deductible for Covered Medical Expenses incurred outside the U.S.A..
2. Charges used to satisfy Deductibles for Covered Medical Expenses incurred outside the U.S.A. will be credited to the Deductible for Covered Medical Expenses incurred in the U.S.A..
3. Charges used to satisfy Deductibles for Covered Medical Expenses incurred for treatment by In-Network providers will be credited to the Deductible for Covered Medical Expenses incurred for treatment by Out-of-Network providers.
4. Charges used to satisfy Deductibles for Covered Medical Expenses incurred for treatment by Out-of-Network providers will be credited to the Deductible for Covered Medical Expenses incurred for treatment by In-Network providers.

MEDICAL BENEFITS **(continued)**

Out-of-Pocket Maximums - This provision does not apply to Prescription Drug charges or to charges for Air Ambulance service. The Deductible is NOT included in the Out-of-Pocket Maximum.

Individual Out-of Pocket Maximum Per Insured Person

In-Network U.S.	**Out-of-Network U.S.**	**Outside-the-U.S.**
$500	$500	$500

Family Out-of-Pocket Maximum

In-Network U.S.	**Out-of-Network U.S.**	**Outside-the-U.S.**
$1,000	$1,000	$1,000

NOTES:

1. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred in the U.S.A. will be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred outside the U.S.A..
2. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred outside the U.S.A. will be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred in the U.S.A..
3. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by In-Network providers will be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by Out-of-Network providers.
4. Charges used to satisfy Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by Out-of-Network providers will be credited to the Out-of-Pocket Maximums for Covered Medical Expenses incurred for treatment by In-Network providers.

SCHEDULE OF BENEFITS
(Continued)

Percentage Payable

Outpatient Treatment of Mental Illness and/or Substance Abuse

In-Network	**Out-of-Network**	**Out-of-U.S.**
90% after Deductible	90% after Deductible	90% after Deductible

Inpatient Treatment of Mental Illness and/or Substance Abuse

In-Network	**Out-of-Network**	**Out-of-U.S.**
90% after Deductible	90% after Deductible	90% after Deductible

Well Baby Care and Preventive Care Benefits

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Mammogram Expenses

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Prostate Cancer Screenings

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Gynecological Cancer Screenings

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Colorectal Expenses for Cancer Screenings

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Immunizations (Including Travel)

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Lead Screenings

In-Network	**Out-of-Network**	**Out-of-U.S.**
100% no Deductible	100% no Deductible	100% no Deductible

Hospital, Surgical and other Covered Medical Expense

In-Network	**Out-of-Network**	**Out-of-U.S.**
90% after Deductible	90% after Deductible	90% after Deductible

Percentage Payable *(continued)*

Emergency Room

In-Network	**Out-of-Network**	**Out-of-U.S.**
90% after Deductible	90% after In-Network Deductible	90% after Deductible

Ground/Air Ambulance

In-Network	**Out-of-Network**	**Out-of-U.S.**
90% after Deductible	90% after In-Network Deductible	90% after Deductible

Prescription Drugs

In-Network	**Out-of-Network**	**Out-of-U.S.**
90% Deductible Waived	90% after Deductible	90% after Deductible

However, Deductibles will be waived for expenses incurred in connection with an Accidental Injury that results in an Emergency Medical Condition.

All inpatient Hospital Confinements in the U.S.A. and air ambulance service anywhere must be pre-certified. *See page 25 for details and penalties for non-compliance.*

Maternity /Obstetrical
Covered the same as any other condition

SCHEDULE OF BENEFITS
(Continued)

MEDICAL BENEFTIS (continued)
Maximum Benefits

Lifetime Maximum Benefit……	Unlimited
Out-patient Mental Illness/Substance Abuse Maximum……	No visit limit
In-patient Mental Illness/Substance Abuse Maximum……..	No days limit
Well-Baby Care/Adult Preventive Care……	No dollar maximum
Speech/Physical/Occupational Therapy Maximum Visits (combined)……	60 visits per calendar year
Spinal Manipulation/Acupuncture/Acupressure Maximum Visits (combined)…	20 visits per calendar year
Applied Behavior Analysis (for treatment of autism spectrum disorder)…….	Plan Coinsurance after Deductible
Treatment of Infertility……..	Covered only to diagnose condition
Home Health Care Maximums……	120 visits per calendar year
Temporomandibular joint dysfunction Lifetime Maximum ……	$1,000 lifetime maximum
Skilled Nursing Facility Maximums…….	120 days per calendar year
In-patient Physical Rehabilitation Facility Maximums…….....	120 days per calendar year
Hospice Care Maximum…….….	Unlimited
Scalp Hair Prosthesis Maximum Per Insured Person…….…...	$ 500 per calendar year
Hearing Aid Maximum Per Insured Dependent…….....	Once per ear every 3 years up to $1,000 per hearing aid unit necessary for dependent children up to age 24
Daily Hospital Room and Board Limit……..…..	The Hospital's average daily rate for semi-private accommodations. However, the limit for charges for confinement in an intensive care unit will be two times the Hospital's average daily rate for semi-private accommodations. Private Room rate is covered if no semi-private room equivalent is available**.**

SCHEDULE OF BENEFITS
(Continued)

DENTAL BENEFITS

Classification

All Eligible Employees and their Dependents

Percentage Payable	
Part I (Preventive) Expense (*ded. waived*)……	100%
Part II (Basic) Expense (*after ded*.)……	80%
Part III (Major) Expense (*after ded*.)……	50%
Orthodontics (*for Dependent Children up to age 19 after ded*.)……	50%
Dental Deductible	
Individual Dental Deductible (per calendar year) Per Insured Person……..	$ 25
Family Dental Deductible (per calendar year)……	$ 50
The Dental Deductible does not apply to Part I (Preventive) Expense.	
Orthodontic Deductible (per lifetime)……..	$ 25
Maximum Benefits	
Calendar Year Maximum Benefit Per Insured Person……	$2,000
Lifetime Orthodontic Maximum Per Insured Person……	$1,500

VISION CARE BENEFITS

Classification
All Eligible Employees and their Dependents

Schedule of Vision Care Services and Supplies

Percentage Payable

Vision Examination……100% (deductible waived)
Lens ……100% (deductible waived)
Frames……100% (deductible waived)

Services and Supplies	**Maximum Allowance Per Insured Person**
Vision Examination	every 12 months
Lenses, Frames and Hardware	$250 every 12 months

DEFINITIONS

"Accidental Injury" means bodily Injury caused by an accident occurring while the Policy is in force with respect to the person whose Injury is the basis of claim and resulting directly and independently of all other causes in a covered loss. This includes related conditions and recurrent symptoms of such Injury.

"Acupressure or **Acupuncture"** seeks to remedy illness through either the application of deep finger pressure or needles at points located along an invisible system of energy channels called meridians.

"Active Service" An Employee will be considered in Active Service if he or she is performing in the customary manner all of the regular duties of his or her employment on a regularly scheduled work day at his or her usual place of employment or at some location to which the Participating Employer's business requires him or her to travel. An Employee will be considered in Active Service on a regularly scheduled non-work day if he or she was in Active Service on the immediately preceding scheduled work day.

"Alternative Therapies" Coverage is provided for certain alternative therapies that are recognized as medically accepted practices in the country in which the treatment is provided. Coverage is extended for medically necessary indications when administered by a health care provider who is legally qualified and practicing within the scope of their license/qualification.

"Applied Behavior Analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between the environment and behavior.

"Brand Name Drug" is a Prescription Drug which is (1) manufactured and marketed under a trademark or name by a specific drug manufacturer; and (2) identified as a Brand Name Drug by the Insurance Company.

"Certificate" means a written statement prepared by the Insurance Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an Employee is entitled;

2. to whom the benefits are payable; and

3. limitations or requirements that may apply.

"Civil Union" means a legal union between two individuals of the same sex. "Party" or "party to a civil union" means an individual who is a party to a civil union.

"Covered Dental Injury" means an Injury caused by a sudden and violent external force. The Injury must be unexpected and unavoidable. A chewing Injury is not a Covered Dental Injury.

"Covered Emergency Evacuation Expense(s)" means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

"Creditable Coverage" means an Insured had prior coverage under: A group health benefit plan; A health benefit plan; Part A or Part B of Title XVIII of the U.S. Social Security Act; Title XIX of the U.S. Social Security Act; Chapter 55 of Title 10, United States Code; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; A health plan offered Chapter 89 of Title 5, United States Code; A public health plan as defines in federal regulations; or A health benefit plan under the Peace Corps Act.

"Custodial Care" means care or services which are not intended primarily to treat a specific Injury or Sickness (including Mental Illness and/or Substance Abuse). Custodial Care includes, but is not limited to:

1. services related to watching or protecting a person
2. services related to performing or assisting a person in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting into or out of bed, toileting, eating, preparing foods or taking medications that can usually be self-administered; and
3. services not required to be performed by trained or skilled medical or paramedical personnel.

"Dentist" means a person other than an Insured Person who: (a) is licensed to practice Dentistry; and (b) practices within the scope of his or her license. A dental hygienist, denturist or Physician will be considered a Dentist when he or she performs any dental service that is within the scope of his or her license.

"Dental Treatment Plan" means the Dentist's report of recommended treatment on a form accepted by the Sponsor that: (a) itemizes the dental procedures and charges required for the necessary care of the mouth; (b) lists the charges for each procedure; and (c) is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials required by the Insurance Company.

"Dependent" means an Employee's Spouse, Domestic Partner or Dependent Child.

"Dependent Child" or **"Dependent Children"** mean any child(ren) of the Employee, including a natural, step, foster or adopted child(ren) who is:

1. to age 26;
2. 26 years of age or over and mentally or physically incapable of earning a living and primarily supported by the Insured Employee, provided the Insured Employee submits proof of the child's incapacity and dependency to the Insurance Company within 60 days before the date the Dependent Child fails to qualify under (1) or (2) above. If the Insured Employee fails to furnish the requested proof before the Dependent Child reaches the age limit, coverage for the Dependent Child will not be extended past the age limit. If coverage is extended, the Insurance Company may request that the Insured Employee submit satisfactory proof of the Dependent Child's continued incapacity and dependency to the Insurance Company on an annual basis. If the Insured Employee fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child will terminate at the end of that 31-day period.

***** A foster or adopted child meets the definition of dependent the date the child is placed in foster care or placed for adoption.

"Domestic Partner" means an opposite or same sex partner who has met all of the following requirements for at least 12 consecutive months: (a) resides with the Insured Person at the same permanent residence; (b) is not married to the Insured Person under either statutory or common law; (c) is not related by blood to the Insured Person to a degree of closeness that would prohibit a legal marriage in the jurisdiction in which they reside; (d) is at least the age of consent in the jurisdiction in which they reside; (e) neither the Insured Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner and (f) is financially interdependent with the Insured Person and has provided the Participating Employer with at least two (2) of the following documents evidencing such financial interdependence:

- joint ownership of real property or a common leasehold interest in real property
- common ownership of an automobile
- joint bank account
- a will in which one partner designates the other as primary beneficiary
- a beneficiary designation form for a retirement plan, or life insurance policy signed and completed to the effect that one partner is the primary beneficiary of the other
- if the Insured Person and Domestic Partner reside in a jurisdiction which provides for registration of Domestic Partners, they have so registered and provided the Participating Employer with evidence of such registration.

The Insurance Company also requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

"Durable Medical Equipment" means equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of Sickness or Injury; and (d) is appropriate for use in the home.

"Emergency Evacuation" means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness: (1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or (3) both (1) and (2) above. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

"Emergency Sickness" means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place their life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom.

"Employee" means a full-time or part-time Employee of the Participating Employer, including Employees of one or more subsidiary corporations, and the Employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the Employer and such affiliated corporations, proprietorships or partnerships is under common control. Employee shall exclude, in any case, part-time Employees, temporary Employees and Employees who work for the Participating Employer less than the number of hours per week indicated in the Schedule of Benefits**.**

"Employer" means the Participating Employer .

"Evidence of Insurability" means a statement or medical evidence of health that determines if a person qualifies for coverage under the Policy.

"Expatriate" means an Employee who is working outside his country of permanent residence.

"Free-Standing Surgical Facility" means an institution which is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions and which: (a) has a medical staff including Physicians, Registered Graduate Nurses and licensed anesthesiologists; (b) maintains at least two operating rooms and one recovery room, diagnostic X-ray and laboratory facilities, equipment for emergency care, a blood supply and medical record-keeping facilities; and (c) has agreements with Hospitals for immediate acceptance of patients requiring Hospital Confinement on an inpatient basis.

"Generic Drug" is a Prescription Drug which is: (1) chemically equivalent to a Brand Name Drug whose patent has expired; and (2) identified as a Generic Drug by the Insurance Company.

"Grace period" is the 31 days following a premium due date during which premium payment may be made.

"Home Health Aide" means a certified or trained professional who provides services through a Home Health Care Agency which:

1. are not required to be performed by an RN, LPN or LVN;
2. primarily aid the Insured Person in performing the normal activities of daily living while recovering from an Injury or Sickness; and
3. are described under the Home Health Care Plan.

"Home Health Care Agency" means an agency or organization that:

1. is licensed, if required, by the appropriate licensing body to provide home health services and supplies;
2. is primarily engaged in nursing and other therapeutic services;
3. has its policies set up by professionals associated with the agency.

"Home Health Care Plan" means a program for continued health care and treatment in the Insured Person's home. It must either (a) follow within 24 hours of and be for the same or related cause(s) as a period of Hospital or Skilled Nursing Facility confinement; or (b) be in lieu of a Hospital or Skilled Nursing Facility confinement. It must be set up, approved in writing and renewed every 60 days by a Physician. Such Physician must certify that the proper treatment would require confinement as an inpatient in a Hospital or Skilled Nursing Facility if the services and supplies were not provided under a Home Health Care Plan. The Physician must also examine the Insured Person at least once a month.

"Hospice" means a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent Hospice administration and it helps the patient cope with physical, psychological, spiritual, social and economic stresses. The Hospice administration must meet the standards of the National Hospice Organization and any licensing requirements.

"Hospice Benefit Period" means a period that begins on the date the attending Physician certifies that the Insured Person is a terminally ill patient who has less than six months to live. It ends after six months (or such later period for which treatment is certified) or on the death of the Insured Person, if sooner.

"Hospice Care Expenses" are the Reasonable and Customary Charges made by a Hospice for the following services or supplies:

1. charges for inpatient care;
2. charges for drugs and medicines;
3. charges for part-time nursing by an RN, LPN or LVN;
4. charges for physical and respiratory therapy in the home;
5. charges for the use of medical equipment;
6. charges for visits by licensed or trained social workers, Psychologists or counselors;
7. charges for bereavement counseling of the Insured Person's Immediate Family prior to, and within three months after the Insured Person's death.
8. charges for respite care for up to five days in any 30 day period;

The term "respite care" means care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill Insured Person.

"Hospital" means (a) an institution constituted, licensed and operated in accordance with the laws pertaining to Hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of Injury and Sickness, and which provides such treatment for compensation, by or under the supervision of Physicians, on an inpatient basis with continuous 24-hour nursing service by Registered Graduate Nurses; or (b) an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare and is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals; or (c) an institution which specializes in treatment of Mental Illness, alcoholism, drug addiction or other related illness and which provides residential treatment programs, but only if that institution is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions. The term Hospital will also include a Free-Standing Surgical Facility but will not include an institution which is, other than incidentally, a place for rest, a place for the aged, or a nursing home.

"Hospital Confinement" or **"Confined In a Hospital"** an individual will be considered Confined in a Hospital if he or she is a registered bed patient in a Hospital upon the recommendation of a Physician or is an outpatient in a Hospital because of (a) surgery; (b) emergency care of an Injury within 48 hours after the Injury is received; or (c) tests ordered by a Physician as a planned preliminary to inpatient admission to the same Hospital within four days. In addition, an individual will be considered Confined in a Hospital during partial confinement for treatment of Mental Illness, Substance Abuse or other related illness.

For the purpose of determining the benefits payable, two days of partial confinement in a Hospital will be considered one day of Hospital Confinement. Partial confinement means continuous treatment for at least three hours but not more than 12 hours in any 24-hour period.

"Immediate Family" includes an Insured Person's Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), aunt, uncle, niece, nephew, or grandchild.

"Infertility" means the presence of a demonstrated condition recognized by a license Physician and surgeon as a cause of Infertility; or the inability to conceive a Pregnancy or carry a Pregnancy to a live birth after a year or more of sexual relations without contraception.

"Injury" means bodily injury resulting directly from an accident and independently of all other causes. The Injury must occur and disability must begin while the Employee is insured under this policy.

"Insurance Company" means Delaware American Life Insurance Company. Any references to the terms "we", "us", and "our" will be deemed references to the Insurance Company.

"Insured" means an Employee insured under this Policy.

"Insured Dependent" means an Insured Dependent Child or an Insured Spouse, for whom premium is paid while covered under the Policy.

"Insured Dependent Child" or **"Insured Dependent Children"** mean the Employee's Dependent Child(ren), for whom premium is paid while covered under the Policy.

"Insured Employee" means an Employee for whom premium is paid while covered under the Policy.

"Insured Person" means an Insured Employee or an Insured Dependent**.**

"Insured Spouse" means the Employee's Spouse, for whom premium is paid while covered under the Policy.

"Late Entrant" means an Employee or Dependent who enrolls for contributory coverage more than 30 days after his or her eligibility date.

"Medically Necessary" means that a service or supply is determined by the Insurance Company to be medically appropriate and: (a) necessary to meet the basic health needs of the Insured Person, (b) rendered in the most cost-efficient manner and type of setting appropriate for delivery of the service or supply, (c) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or governmental agencies that are accepted by the Insurance Company, (d) consistent with the diagnosis of the condition, (e) required for reasons other than the convenience of the Insured Person or his or her Physician. The service or supply must also be demonstrated through prevailing peer-review medical literature to be either: safe and effective for treating or diagnosing the Injury or Sickness for which their use is proposes, or safe with promising efficacy (I) for treating a life threatening Injury or Sickness, (ii) in a clinically controlled research setting, and (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

For purposes of this definition, “life threatening” means an Injury or Sickness which is more likely than not to cause death within one year of the date of request for treatment.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury or Sickness does not mean that it is Medically Necessary. The definition of Medically Necessary as used in the Policy relates only to the insurance provided by the Policy and may differ from the way a Physician may define medical necessity.

With respect to confinement in a Hospital as an inpatient, "Medically Necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

“Medically Necessary Emergency Evacuation Service” means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.

“Medicare” means the program of medical care benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as amended.

“Mental Illness” means any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors. Also called emotional illness, mental/nervous disorder and psychiatric disorder.

“Miscellaneous Services and Supplies” includes any charges, other than charges for Room and Board, made by a Hospital on its own behalf for necessary medical confinement. Miscellaneous Services and Supplies will also include any charges, by whomever made, for professional ambulance services to or from the nearest Hospital where the medical care and treatment necessary for the individual can be provided, and any charges, by whomever made, for the administration of anesthetics during the Hospital Confinement, but will not include any charges for special nursing fees, dental fees or medical fees.

“Network Pharmacy” is a pharmacy, which has (1), entered into an agreement with the Insurance Company or its designee to provide Prescription Drugs to Insured Persons; (2) has agreed to accept specified reimbursement rates for dispensing Prescription Drugs and (3) has been designated by the Insurance Company as a Network Pharmacy. A Network Pharmacy can be either Retail or a Mail Service Pharmacy.

“Participating Employer” means an Employer who is part of a trust established to insure Employees of the Employer or any parent, subsidiary or its affiliated companies under a common control.

“Physician” means an individual who is operating within the scope of his or her license and is licensed to prescribe and administer drugs or to perform surgery. **Note:** For the purpose of the Policy, a duly licensed Dentist, chiropractor, podiatrist or other practitioner acting within the scope of their licenses will be considered on the same basis as a Physician to the extent that the services are covered under the Policy.

It will not include an Employee or his or her Spouse, daughter, son, father, mother, sister or brother.

“Podiatry” treatment is dedicated to the diagnosis, treatment and prevention of disease and disorders affecting the foot, ankle and lower extremities.

“Policyholder” may be an Employer, including any parent, subsidy or affiliated company or the trust which the Employer created or participates in.

"Pre-existing Condition" is an Injury or Sickness for which the Insured received medical treatment, consultation, care or services including diagnostics measures, or had taken prescribed drugs or medicines in the three months prior to the Insured's effective date.

"Preferred Drug List" is a list of drugs selected as providing the highest therapeutic and economic value in their classes.

"Pregnancy" includes miscarriage, abortion, childbirth or any complications thereof.

"Prescription Drugs" are a medication, product or device which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under the Plan, this definition includes insulin and the following diabetic supplies: insulin syringes with needles; blood testing strips – glucose; urine testing strips – glucose; ketone testing strips and tablets; lancets and lancet devices.

"Psychologist" means an individual who is duly licensed or certified as a Psychologist in those jurisdictions where statutory or nonstatutory licensure or certification exists or, in those jurisdictions where neither exists, an individual who is duly qualified as a professional Psychologist by a recognized psychological association.

"Reasonable and Customary Charge" means the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed.

"Registered Graduate Nurse" means a professional nurse who has the right to use the title "Registered Nurse" and the abbreviation "R.N."

"Room and Board" includes all charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

"Serious Injury" or **"Serious Sickness"** mean Injury or Sickness certified as being dangerous to life by a legally qualified medical practitioner

"Serious Mental Illness" is defined as schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorder; panic disorder; anorexia nervosa; bulimia nervosa; schizoaffective disorder and delusional disorder.

"Sickness" means any physical Sickness, Mental Illness, Substance Abuse or functional nervous disorder diagnosed by a Physician. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. The term **"**Sickness" also includes Pregnancy.

"Skilled Nursing Facility" means a lawfully operating institution engaged mainly in providing treatment for people convalescing from Injury or Sickness. It must have:

1. organized facilities for medical services; and
2. 24 hour nursing service by RNs; and
3. a capacity of six or more beds; and
4. daily medical records for each patient; and
5. a Physician available at all times.

If a Skilled Nursing Facility does not have semi-private rooms, "semi-private room rate" means 80% of that facility's daily charge for its lowest rate private room.

Skilled Nursing Facility does not include: rest homes, homes for the aged, and places for Custodial Care or detoxification facilities.

"Spinal Manipulation" is a form of manual therapy where an application of forces to structures such as muscles, joints and bones is presented, where the goal is the restoration of normal joint motion and the elimination of pain secondary to disturbed biomechanics.

"Spouse" means the Insured Employee's lawful spouse (not including a spouse who is legally separated from the Insured). The Term Spouse will include a Domestic Partner.

"Substance Abuse" means the overindulgence in and dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health, or the welfare of others.

"Temporomandibular Joint Dysfunction" is a condition of facial pain in the joints of the lower jaw and is also known as myofacial pain dysfunction syndrome or TMJ.

"Total Disability" or **"Totally Disabled"** an Employee will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is completely unable to perform the duties of his or her regular occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit.

A Dependent will be considered Totally Disabled during any period when, as a result of Injury or Sickness, he or she is unable to engage in the normal activities of a person of the same age and sex.

"Transportation" means moving the Insured Person during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

"Waiting Period", shown in the Schedule of Benefits, means the continuous length of time an Employee must serve in an eligible class to reach his eligibility date.

ELIGIBILITY FOR INSURANCE

EMPLOYEES

Each Employee in a class of Eligible Employees will become eligible for insurance on the date he or she completes the Waiting Period, if any. Any Waiting Period will be waived for an Employee previously insured under the Policy, whose insurance terminated for a reason other than cancellation of his or her payroll deduction order, if the Employee becomes employed in one of the classes of Eligible Employees within one year after his or her insurance terminates. The classes of Eligible Employees and the Waiting Period are shown in the Schedule of Benefits.

DEPENDENTS

Each Eligible Employee will be eligible for Vision Benefits, Dental Benefits and Medical Insurance with respect to his or her Dependents on the latest of:

1. the effective date of the Policy; or
2. the date upon which he or she acquires a Dependent; or
3. the effective date of the Employee's insurance under the Policy.

EFFECTIVE DATE OF INSURANCE - U.S. CITIZENS ONLY

Contributory – Coverage(s) other than Medical Insurance

If the Participating Employer plan under the Policy or any coverage other than Medical Insurance afforded there under is issued on a contributory basis, each Employee may elect such insurance by signing an enrollment form approved by the Participating Employer and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the Participating Employer on or before that date; or
2. the date on which the enrollment form is received by the Participating Employer if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the Participating Employer more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

If the Employee is not in Active Service on the date insurance would normally become effective, the effective date of his or her insurance will be the date he or she returns to Active Service

EFFECTIVE DATE OF INSURANCE - U.S. CITIZENS ONLY (continued)

EMPLOYEES (continued)

Contributory - Medical Insurance

If the Participating Employer plan under the Policy or the Medical Insurance afforded there under is issued on a contributory basis, each Employee may elect such insurance by enrolling on a form approved by the Participating Employer and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the Participating Employer on or before that date; or
2. the date on which the enrollment form is received by the Participating Employer, if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which the enrollment form is received by the Participating Employer, if that date is within a 30-day Special Enrollment Period; or
4. the date for which the first premium for the Employee's coverage is paid.

If the Employee fails to enroll for contributory Medical Insurance as set forth in 1., 2. or 3. above, such Employee may again enroll for coverage during the 30-day period following the one year anniversary of the date on which he or she was originally eligible or, if later, during the 30-day period following the one year anniversary of the beginning of a Special Enrollment Period.

Annual Enrollment. The Annual Enrollment Period, shown in the Schedule, is a period of time during which any Eligible Insured's may apply for insurance or elect to make changes in their amount of insurance.

DEPENDENTS

Contributory – Coverage(s) other than Medical Insurance

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the Participating Employer on or before the date he or she becomes eligible; or
2. the date the enrollment form electing Dependent coverage is received by the Participating Employer, if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. on the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the Participating Employer more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is Confined in a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.

Contributory - Medical Insurance

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the Participating Employer on or before the date he or she becomes eligible; or
2. the date the enrollment form electing Dependent coverage is received by the Participating Employer if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. on the date the enrollment form electing Dependent coverage is received by the Participating Employer if that date is within a 30 day Special Enrollment Period. Coverage for certain Dependents will be effective earlier. See the following "Special Enrollment Periods" section for details; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

Special Enrollment Periods

A Special Enrollment Period is a 30-day period during which an Eligible Employee who has previously declined to enroll under the Policy may enroll himself or herself or his or her Dependents. A Special Enrollment Period will be granted under the following conditions:

1. Loss of Other Coverage

a. the Eligible Employee or Dependent was covered under another group benefit plan or had health insurance coverage at the time coverage under the Policy was offered; and
b. the Eligible Employee declined coverage under the Policy, in writing, on the basis of the other coverage; and
c. the Eligible Employee or Dependent lost the other coverage as a result of legal separation, divorce, death, termination of employment or a reduction in the number of hours of employment or Employer contributions toward such coverage were terminated, or
d. the Eligible Employee's or Dependent's COBRA coverage is exhausted.

   If the Eligible Employee or Dependent lost the other coverage as a result of his or her failure to pay premiums or for cause (including but not limited to making a fraudulent claim), that Eligible Employee or Dependent will not have a Special Enrollment Period.

2. Other

a. Dependents are entitled to a special 30 day enrollment period if they become Dependents through marriage, birth, adoption or placement for adoption. The effective date of coverage for such a Dependent will be retroactive to the date of marriage, birth, adoption or placement for adoption.

EFFECTIVE DATE OF INSURANCE - NON- U.S. CITIZENS

EMPLOYEES

Contributory – All Coverage(s)

If the Participating Employer's plan under the Policy or any coverage afforded there under is issued on a contributory basis, each Employee may elect for such insurance by signing an enrollment form approved by the Participating Employer and acceptable to the Insurance Company. The effective date of his or her insurance will be the latest of:

1. the date on which the Employee becomes eligible for coverage under the Policy, if the enrollment form is received by the Participating Employer on or before that date; or
2. the date on which the enrollment form is received by the Participating Employer if that date is within the 30-day period immediately following the date he or she becomes eligible for coverage under the Policy; or
3. the date on which he or she is accepted for insurance by the Insurance Company, if the enrollment form is received by the Participating Employer more than 30 days after the date he or she becomes eligible for coverage under the Policy or again elects to be insured after his or her insurance has terminated, because of cancellation of a payroll deduction order. To determine an Employee's acceptability, the Insurance Company will require medical Evidence of Insurability and may require that the evidence be presented by the Employee at his or her own expense; or
4. the date for which the first premium for the Employee's coverage is paid.

DEPENDENTS

Contributory – All Coverage(s)

An Insured Dependent's coverage under the Policy will become effective on the latest of:

1. the date he or she becomes eligible for coverage under the Policy, if the enrollment form electing Dependent coverage is received by the Participating Employer on or before the date he or she become eligible for coverage under the Policy; or
2. the date the enrollment form electing Dependent coverage is received by the Participating Employer if it is received within 30 days of the date he or she becomes eligible for coverage under the Policy; or
3. the date the Insurance Company approves medical Evidence of Insurability for each Dependent if the enrollment form electing Dependent coverage is received by the Participating Employer more than 30 days from the date he or she becomes eligible for coverage under the Policy. Such Evidence of Insurability must be provided for each Dependent at the Employee's own expense; or
4. the date for which the first premium for the Dependent's coverage is paid.

If an Employee and his or her Spouse are both insured under the Policy as Employees, their Dependent Children may only be insured as Dependents of one of the Insured Employees. No person may be insured as both an Employee and a Dependent.

If a Dependent is confined to a Hospital or other medical facility on the date insurance would normally become effective, the insurance will become effective upon discharge from the Hospital or other facility.

TERMINATION OF INSURANCE

EMPLOYEES

An Insured Employee's coverage under the Policy will automatically terminate on the earliest of:

1. the date the Employee ceases to be in a class of Eligible Employees or ceases to qualify as an Employee;
2. the date the Employee's Employer ceases to be a Participating Employer under the Policy;
3. the date the Policy is discontinued;
4. the last day for which any required contribution has been made;
5. 90 days after the date the Employee returns to the U.S to establish residency or country of primary residence;
6. the date the Employee ceases to be in Active Service, except as provided below:

Temporary Layoff or Leave of Absence. If an Employee's Active Service terminates because of temporary layoff or leave of absence, the insurance will be continued until the Participating Employer ceases to pay premiums for the Employee or otherwise cancels the insurance. But in no event will the insurance be continued for more than 60 days following termination of Active Service.

Any continuation of insurance must be in accordance with a plan which precludes individual selection.

DEPENDENTS

An Insured Dependent's coverage under the Policy will automatically terminate upon the earliest of the following:

1. the date the Insured Employee's coverage under the Policy ends; or
2. the last day for which any required contribution has been made;
3. the date the person ceases to qualify as a Dependent.

CONTINUATION OF HEALTH INSURANCE COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a U.S. law that applies to employers in the U.S. with more than 20 employees. If your employer pays U.S. withholding tax related to your employment, you are eligible for COBRA continuation coverage when a qualifying event occurs.

This provision describes an Insured Person's rights under COBRA to continue the healthcare coverage which would otherwise terminate under the Policy.

Coverage for an Insured Person will be continued for the applicable Continuation Period described below if insurance under the Policy is terminated due to one of the Qualifying Events described below. The continued coverage will be at the Insured Person's expense and will be identical to the coverage provided under the Policy at the time of the Qualifying Event. If more than one Qualifying Event occurs, coverage may be extended only for the longest Continuation Period for which the Insured Person is eligible under the terms of this provision.

Continuation Periods and Qualifying Events

18-Month Continuation Period

For any Insured Person, coverage may be continued for up to 18 months if coverage would otherwise terminate under the Policy due to one of the following Qualifying Events:

1. voluntary or involuntary termination of employment, other than for gross misconduct; or
2. reduction in work hours.

11-Month Extension for Disability

The 18-month Continuation Period described above may be extended for an additional 11 months if at the time of the Qualifying Event described above (or at any time during the first 60 days of continued coverage), the Insured Person is determined to be disabled by the Social Security Administration. This 11-month extension applies to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment.

36-Month Continuation Period for Dependents Only

Coverage for an Insured Dependent may be continued for up to 36 months, if coverage would otherwise terminate due to the following Qualifying Events:

1. the Employee’s death;
2. the divorce or legal separation of the Employee and his or her Insured Dependent Spouse;
3. the Employee’s child no longer meets the Policy's definition of Dependent.
4. the Employee becomes entitled to Medicare.

If the Employee does not lose coverage due to Medicare entitlement but later loses coverage due to another Qualifying Event (such as voluntary or involuntary termination or reduction in work hours), coverage for Insured Dependents in such cases may be continued for up to 36 months from the date the Employee first became entitled to Medicare.

A child who is born to or placed for adoption with the Insured Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the COBRA administrator of the birth or adoption.

Election Period

For COBRA continuation of coverage to become effective, an Insured Person eligible for the continuation described above must elect the continuation in writing within 60 days of the later of:

1. the date the Insured Person would otherwise lose coverage due to the Qualifying Event; or
2. the date the Insured Person is notified of the right to elect the continuation of coverage.

The election must be in writing on a form provided by the COBRA administrator designated by the Participating Employer. The form must be completed and returned within the 60-day period indicated above.

If the Qualifying Event is divorce, legal separation, or a child who no longer qualifies as a Dependent under the Policy, the Insured Person must provide notification within 60 days of the date he or she would lose coverage.

If the Insured Person is disabled and qualifies for continued coverage under the 11-month Extension for Disability described above, the Insured Person must notify the COBRA administrator within 60 days of the final determination by the Social Security Administration that he or she is disabled.

Payment of Premium

The Insured Person who has elected to continue coverage shall be solely responsible for the payment of premium for the continued coverage. If election of COBRA continuation is made after the date of the Qualifying Event, premium payment for the continuation of coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments.

Termination of COBRA Continuation

The continued coverage will cease on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium is due and unpaid after any applicable Grace Period;
3. the date the Insured Person becomes covered under another group health insurance Plan. This may not apply if the Insured Person has a Pre-existing Condition which was covered under the Policy but is not covered under the new Plan. However, for Calendar years beginning after July 1, 1997, if the new Plans Pre-existing Condition exclusion would not apply because your Creditable Coverage under the Policy satisfies the new Plan's requirements, then coverage under the Policy pursuant to COBRA may be terminated;
4. the date the Insured Person becomes eligible under Medicare;
5. the date the applicable period of continuation is exhausted, or the Lifetime Maximum Benefit under the Policy, if applicable, is paid on behalf of the Insured Person;
6. the first day of the month which begins 30 days after the date the Insured Person receives a final determination from the Social Security Administration that he or she is no longer disabled if continued for the 11-month Extension for Disability described above.

THREE MONTH CONTINUATION OF HEALTH INSURANCE COVERAGE

This provision applies to those Insured Persons who are not covered by COBRA

This provision describes an Insured Person's rights to continue the medical coverage which would otherwise terminate under the Policy.

Subject to continued premium payment by the Participating Employer coverage for an Insured Person will be continued for a period of three months if insurance under the Policy is terminated due to one of the Qualifying Events described below. The continued coverage will be identical to the coverage provided under the Policy at the time of the Qualifying Event.

Qualifying Events

For any Insured Person, coverage may be continued if coverage would otherwise terminate under the Policy due to one of the following Qualifying Events:

1. voluntary or involuntary termination of employment, other than for gross misconduct; or
2. reduction in work hours.

Coverage for an Insured Dependent may be continued if coverage would otherwise terminate due to the following Qualifying Events:

1. the Employee's death;
2. the divorce or legal separation of the Employee and his or her Insured Dependent Spouse;
3. the Employee's child no longer meets the Policy's definition of Dependent.
4. the Employee becomes entitled to Medicare.

A child who is born to or placed for adoption with the Insured Employee during a period of continued coverage will be eligible to become a qualified beneficiary. These qualified beneficiaries can be added to continued coverage upon proper notification to the plan administrator of the birth or adoption.

Election Period

For continuation of coverage to become effective, an Insured Person eligible for the continuation described above must elect the continuation in writing within 31 days of the later of:

1. the date the Insured Person would otherwise lose coverage due to the Qualifying Event; or
2. the date the Insured Person is notified of the right to elect the continuation of coverage.

The election must be in writing on a form provided by the Participating Employer . The form must be completed and returned within the 31-day period indicated above.

If the Qualifying Event is divorce, legal separation, or a child who no longer qualifies as a Dependent under the Policy, the Insured Person must provide notification within 31 days of the date he or she would lose coverage.

Termination of Continued Coverage

The continued coverage will cease on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium is due and unpaid after any applicable Grace Period;
3. the date the Insured Person becomes covered under another group health insurance plan.
4. the date the Insured Person becomes eligible under Medicare;
5. the date the three month period of continuation is exhausted, or the Lifetime Maximum Benefit under the Policy, if applicable, is paid on behalf of the Insured Person.

MEDICAL BENEFITS

Medical Benefits are payable for expenses incurred by each person while insured under the Policy. Such expenses must be for medical treatment that results from Injury or Sickness. Such expenses must also be Medically Necessary and prescribed or ordered by a Physician.

Medical Benefits are determined this way:

1. Subtract any Medical Deductible from Covered Medical Expenses incurred; and
2. Multiply the result by the Percentage Payable that applies to the Covered Medical Expenses.

Medical Benefits payable will not exceed any of the applicable maximum benefits.

Deductibles, Percentage Payable and maximum benefits are shown in the Schedule of Benefits.

Medical Deductible(s)

Individual Medical Deductible

The Individual Medical Deductible, shown in the Schedule of Benefits, applies to each Insured Person once each calendar year. It is a dollar amount of Covered Medical Expenses for which no benefits are payable.

Family Medical Deductible

If, in any calendar year, Covered Medical Expenses used toward the Individual Medical Deductibles of an Insured Employee and his Insured Dependents equals the Family Medical Deductible shown in the Schedule of Benefits, the Individual Deductible will be deemed to be met with respect to Covered Medical Expenses incurred by such Insured Employee and his Insured Dependents for the rest of that calendar year.

COMMON ACCIDENT. If an Insured Employee and one or more of his or her Insured Dependents or if two or more of an Insured Employee's Insured Dependents sustain Injuries in the same accident and, as a result of those Injuries, incur Covered Medical Expenses during the same calendar year in which the accident occurs, only one Medical Deductible will be deducted from the total Covered Medical Expenses incurred for those individuals during the remainder of that calendar year.

Out-of-Pocket Maximum Does not apply to charges for prescription drug charges or to charges for Air Ambulance service. The Deductible is NOT included in the Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximum

If out-of-pocket expense used to meet the percentage of Covered Medical Expenses that an Insured Employee pays due to the Percentage Payable provision exceeds the Individual Out-of-Pocket Maximum for himself or one of his or her Insured Dependents, Medical Benefits for that one Insured Person will be payable at 100% of such Covered Medical Expense. The Individual Out-of-Pocket Maximum applies on a calendar year basis. It is shown in the Schedule of Benefits.

Family Out-of-Pocket Maximum

If out-of-pocket expense used to meet the percentage of Covered Medical Expenses that an Insured Employee pays due to the Percentage Payable provision exceeds the Family Out-of-Pocket Maximum for all Insured Persons in a family in any calendar year, Medical Benefits will be payable at 100% of Covered Medical Expense for the rest of that calendar year. The Family Out-of-Pocket Maximum is shown in the Schedule of Benefits.

Percentage Payable

Medical Benefits are paid at percentages of Covered Medical Expenses incurred. These percentages are called the "Percentage Payable". Where the Percentage Payable is less than 100%, the Insured Person is responsible for the difference. The Percentage Payable is shown in the Schedule of Benefits.

Maximum Benefits

Lifetime Dollar Limits

The benefits provided by your Policy will no longer be subject to a lifetime dollar limit. If you have reached a lifetime dollar limit under your Policy before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits becomes effective, and you are still eligible under your Policy's terms, and that Policy is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Policy. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Other Maximums

In addition to the Lifetime Maximum Benefit, certain Covered Medical Expenses are also subject to other internal limits or maximums. These additional maximums are shown in the Schedule of Benefits.

Pre Certification for U.S Hospital Confinements and any Air Ambulance Service

Pre certification is a program in which the Insurance Company reviews all inpatient Hospital treatment in the U.S. and any request for air ambulance service for medical necessity**.**

Under this program, all U.S. inpatient Hospital Confinements and all requests for air ambulance service must be certified by the Insurance Company. Procedures for requesting certification are outlined below***. If an Insured Person fails to follow these procedures, benefits payable for Covered Medical Expenses for charges incurred in connection with the Hospital Confinement or air ambulance service will be reduced to 50% of what would otherwise be payable.*** Expenses for charges incurred that are not payable because of this penalty are not Covered Medical Expenses and won't count toward the Out-of-Pocket Maximums.

Non-Emergency Hospitalization or Air Ambulance Service

All non-emergency inpatient Hospital admissions in the U.S. and requests for air ambulance service anywhere must be certified in advance by the Insurance Company. An Insured Person or his or her attending Physician must call the Insurance Company for certification at least five calendar days before a non-emergency U.S. inpatient Hospital admission or scheduled air ambulance service. If the Insurance Company determines that the admission or service is Medically Necessary, the Insured Person will be notified that the Hospital admission or air ambulance service has been certified. If the admission or service is not authorized, the Insured Person will be advised of this determination. If the Insured Person does not receive notification prior to the scheduled admission or service date, he or she should contact the Insurance Company to determine the recommendation that it has taken with respect to that Hospital admission or request for air ambulance service.

Pre-Admission Certification (continued)

Emergency Hospitalization or Air Ambulance Service

In an emergency Hospital admission or emergency air ambulance service, a request to certify must be made within 48 hours or on the next business day following the Insured Person's admission or air ambulance service. "Emergency admission or air ambulance service" means an inpatient Hospital admission or air ambulance service for an Emergency Medical Condition.

Important Note

Obtaining a Pre-Admission Certification does not guarantee that the expense will be reimbursed should the expense not be covered for any other reason set forth in this Policy. The Insurance Company reserves the right to review each claim for its' eligibility, and non-eligible expenses shall be denied.

If an Insured Person proceeds with a U.S. inpatient Hospital or an air ambulance service which has been determined as not Medically Necessary, and if a post claim review confirms this determination; no benefits are payable for any charges incurred in connection with that confinement or service.

Covered Medical Expenses

The term Covered Medical Expenses means expenses incurred by or on behalf of an Insured Person for the charges listed below but only if: (a) the expenses are Medically Necessary; and (b) the treatment giving rise to the expenses is prescribed or ordered by an attending Physician. Covered Medical Expense will not include amounts in excess of the Reasonable and Customary Charge. Covered Medical Expenses will be subject to any applicable limitations or maximums shown in the Schedule of Benefits.

The date the service is performed or the supply is purchased is the date Covered Medical Expense is incurred.

1. charges made by a Hospital, on its own behalf, for Room and Board and other Miscellaneous Services and Supplies and for medical care and treatment provided on an outpatient basis;

2. charges made by a facility licensed to furnish treatment of Mental Illness or Substance Abuse, on its own behalf for care and treatment provided on an inpatient basis;

3. charges made by a facility licensed to furnish treatment of Mental Illness or Substance Abuse, on its own behalf for care and treatment provided on an outpatient basis;

4. charges made by a Free-Standing Surgical Facility for services in connection with outpatient surgery, and which are incurred on the day of the surgery or within 48 hours after the surgery;

5. charges for Scalp Hair Prosthesis for hair loss suffered as a result of alopecia areata;

6. charges for an individual hearing aid , per ear, every 3 years, for children less than 24 years of age, covered as a dependent

7. charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment;

Covered Medical Expenses (continued)

8 charges made by a Home Health Care Agency for treatment rendered in an Insured Person's home pursuant to a Home Health Care plan. Covered Medical Expenses for Home Health Care are limited to the following:
(a) part-time or intermittent nursing care by or under the supervision of an RN, LPN or LVN;
(b) part-time Home Health Aide services that consist primarily of caring for the patient;
(c) services provided by a licensed or certified midwife or nurse midwife;
(d) medical social services by licensed or trained social workers, Psychologists or counselors;
(e) services by licensed physical, occupational or speech therapists;
(f) nutrition services provided by a licensed dietitian;
(g) medical supplies attendant to the above services to the extent they are covered under the Policy;

Provided further, that in determining the limit of benefits for services in (a) through (e) above:

(i) each visit by a member of a home health care team (other than a Home Health Aide) will be counted as one home health care visit; and
(ii) four hours or less of Home Health Aide service will be counted as one home health care visit;

9. charges for a Physician's professional services including those of a licensed midwife. Charges made by an assistant surgeon or surgical assistant are Covered Medical Expense when such assistance is: (a) Medically Necessary; (b) such person actively participates in the surgery; and (c) such person is not an Employee of the facility where surgery is performed. Charges made by an assistant surgeon or surgical assistant in excess of 20% of the Reasonable and Customary surgeon's charge for the surgery are not covered;

10. charges made by a Registered Graduate Nurse for professional outpatient nursing services;

11. charges made for anesthesia and its administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental of an oxygen breather; diabetic supplies or other Durable Medical Equipment; physical therapy; prosthetic appliances; dressings; and drugs and medicines lawfully obtainable only upon the written prescription of a Physician;

12. charges made by a Hospice for Hospice Care Expense incurred by a terminally ill Insured Person during a Hospice Benefit Period;

13. charges for professional ambulance service in connection with an Emergency Medical Condition. Covered Medical Expenses for the service are limited to charges for land Transportation to the nearest Hospital equipped to render treatment for the condition. Air Transportation is covered only when Medically Necessary.

14. Oral Contraceptive Drugs or devices used to prevent Pregnancy.

Adult Preventive Care Benefits

Benefits are payable for charges incurred by a Insured Person for certain health examinations that are not due to an Injury or Sickness, subject to any limitations or maximums shown in the Schedule of Benefits. Charges for examinations that diagnose Injury or Sickness will be considered as due to and part of the treatment of the diagnosed condition and will not be considered Covered Medical Expenses under this provision.

Covered Expenses:
The following will be considered Covered Medical Expense under this provision:

1. charges for routine general physical examinations and/or gynecological exam not to exceed:
   - one examination per year for persons age 18 or older
2. charges for Papanicolaou's (Pap) tests; not to exceed one per year
3. charges for electrocardiograms (EKG);
4. charges for X-ray examinations and laboratory tests;
5. charges for routine mammography screening as follows:
   - for women age 35 through age 39, one baseline mammogram;
   - for women age 40 through age 49, one baseline mammogram every one or two years, based upon recommendation of a Physician
   - for women age 50 or older, one mammogram every year;
   - for women based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population, one mammographic examination;
6. charges for routine ear examination when performed by an audiologist or otolaryngologist, not to exceed one every two years
7. charges for prostate cancer screening (PSA) test for men being age 50 or older;
8. charges for CA-125 monitoring of ovarian cancer subsequent to treatment;
9. charges for immunizations including travel immunizations;
10. for persons age 50 or older, screening with annual fecal occult blood tests (3 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable screening tests available.

The following are not considered Covered Medical Expenses under this provision:
1. charges for tests or examinations that diagnose Injury or Sickness;
2. charges for tests or examinations given while the Insured Person is Confined in a Hospital or other medical facility.

Women's Preventive Care Benefits

Benefits are payable for well-woman preventative care visit annually for adult women to obtain the recommended preventative services that are age and developmentally appropriate, including preconception and prenatal care.

Covered Benefits:

The following services are required by PPACA to be covered for group policies beginning on or after August 1, 2012, non-grandfathered plans will be required to cover the following additional preventative care services for women with no cost sharing:

1. Annual well-woman visits
    a. charges are considered preventive regardless of diagnosis
    b. includes prenatal care visits
2. Screening for gestational diabetes
    a. Women who are 24 to 28 weeks pregnant, and at the first prenatal visit for those who are at high risk of development of gestational diabetes
3. Annual screening and counseling for interpersonal and domestic violence
4. FDA-approved contraception methods, including sterilization and contraceptive education and counseling
5. Breastfeeding support, supplies and counseling
6. HPV (Human Papillomavirus) DNA testing,
    a. Every three years for women 30 or older
7. Annual sexually transmitted infections counseling
8. Annual HIV(Human Immunodeficiency virus) screening and counseling

Coverage for Routine Newborn Care

Benefits are payable for routine charges incurred by an Insured Employee's newborn child as follows, subject to any limitations or maximums shown in the Schedule of Benefits:

1. Hospital charges for routine nursery care during the mother's confinement, not to exceed four days;
2. Physician's charges for circumcision;
3. Physician's charges for visits to the newborn child in the Hospital;
4. Benefits for hearing loss screening tests provided by a Hospital before discharge.

Well Baby/Child Care

Charges incurred for routine preventive care and immunizations of an Insured Dependent Child who is under eighteen years of age will be considered Covered Medical Expense under the Policy even though such charges are not the result of an Injury or Sickness.

Charges for a baseline lead poisoning screening test for children at or around 12 months of age are covered. Lead poisoning screening and diagnostic evaluations for children under the age of six years who are at high risk for lead poisoning are covered as well.

Benefits are subject to any limitations or maximums shown in the Schedule of Benefits.

EMERGENCY MEDICAL EVACUATION BENEFITS

If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside of his or her country of citizenship, the Insurance Company will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to $250,000 for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. An Emergency Evacuation must be ordered by the Insurance Company or a Physician who certifies that the severity or the nature of such person's Injury or Sickness warrants such person's Evacuation.

Covered expenses are those for Transportation and medical treatment, including medical services and medical supplies necessarily incurred in connection with an Insured Person's Emergency Evacuation. All Transportation arrangements made for evacuating such person must be by the most direct and economical route possible. Expenses for Transportation must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting such person; and (c) arranged and authorized in advance by the Insurance Company.

Repatriation of Remains

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside his or her country of citizenship, the Insurance Company will pay for covered expenses reasonably incurred to return his or her body to his or her country of citizenship, up to $25,000.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for Transportation of the remains; and (3) Transportation of the remains by the most direct and economical conveyance and route possible.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Emergency Family Travel

If an Insured Person is hospitalized for more than 5 days, the Insurance Company will pay up to $10,000 for the cost of round-trip economy airfare to bring a person chosen by the Insured Person to and from such Insured Person's bedside if such person is alone.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.

Return of Dependents

If an Insured Person is hospitalized for more than 3 days, the Insurance Company will pay up to $10,000 for the cost of economy airfare for Transportation of the Insured Dependent to his or her country of citizenship or otherwise designated location. This will include an escort to accompany an otherwise unaccompanied minor Dependent Child during the journey.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.

Exclusions and Limitations

In addition to the provisions of the Policy titled "Medical Exclusions" and "General Limitations, the following will apply solely to the benefits afforded under the Emergency Medical Evacuation Benefits:

No benefits are payable for:

- Claims arising from depression or anxiety, mental or nervous disorder, alcohol or drug abuse addiction or overdose;
- Claims arising from elective cosmetic or plastic surgery, except as a result of an accident;
- an Insured Person traveling against the advice of a Physician;
- Claims directly caused by or directly resulting from:
    a. any business or financial contractual obligations of the Insured Person or Insured Person's Immediate Family Member;
    b. Change of plans or disinclination of the Insured Person or Insured Person's Immediate Family Member to travel.

PRESCRIPTION DRUG BENEFITS

Benefits are payable for outpatient Prescription Drugs. The Prescription Drugs must be prescribed for:

- Medically necessary treatment of an accidental injury, sickness or pregnancy.
- Prevention of pregnancy.

Certain Prescription Drugs require Prior Authorization by a Pharmacists or physician from the Insurance Company or its designee.

The Insured Person must be covered under this Prescription Drug Benefit when the prescription is filled.

Network Pharmacy

When a Network Pharmacy is used, the Insured Person pays the Co-payment, if applicable.

If the Prescription Drug Cost is less than the Co-payment, the Co-payment does not apply and the Insured Person pays the Prescription Drug Cost.

Network Pharmacies dispense Generic Drugs whenever possible.

For Generic Drugs, an Insured Person pays the Generic Drug Co-payment, if applicable.

An Insured Person pays the Brand Name Drug Co-payment, if applicable for Brand Name Drugs dispensed under either of the following conditions:

- There is no equivalent Generic Drug for substitution.
- The Physician orders a Brand Name Drug. This is usually done by writing “Dispense as written” on the prescription.

Non-Network Pharmacy

When a Non-Network Pharmacy is used, the Insured Person must pay for the entire cost of each prescription at the time it is filled. Then the Insured Person must submit a claim. Benefits are payable at the Non-Network level under Medical Benefits.

Mail Service Network Pharmacy

A mail service pharmacy option has been provided for convenience. If the mail service is used, the Insured Person must pay the Co-payment.

There is no coverage for Prescription Drugs dispensed by a Non-Network Mail Service Pharmacy.

Mail service pharmacies dispense Generic Drugs whenever possible.

For Generic Drugs, an Insured Person pays the Mail Service Generic Drug Co-payment.
An Insured Person pays the Mail Service Brand Name Drug Co-payment for Brand Name Drugs dispensed under either of the following conditions:

- There is no equivalent Generic Drug for substitution.
- The physician orders a Brand Name Drug. This is usually done by writing “Dispense as written” on the prescription.

Supply Limits

Retail Pharmacy
If the Prescription Drug is dispensed by a retail Pharmacy, the following limits apply:

- Up to a 30-day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size. Some products may be subject to additional supply limits adopted by the Insurance Company. A list of current additional supply limits may be obtained from the Insurance Company. Up to three cycles can be purchased at one time if a Co-payment is paid for each cycle supplied.

- A one cycle supply of an oral contraceptive. Up to three cycles can be purchased at one time if a co-payment is paid for each cycle supplied.

Mail Service Pharmacy
If the Prescription Drug is dispensed by a mail service pharmacy, the supply limit is up to a 90 day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size or any additional supply limits adopted by the Insurance Company. A list of current supply limits may be obtained from the Insurance Company.

Identification Card
If an Insured Person does not show the identification card at the time Prescription Drugs are obtained, the Insured Person will be required to pay the full cost of the Prescription Drug and get payment from the Insurance Company. In that case, benefits are calculated at the predominant contract reimbursement rate for a Network Pharmacy (including any sales tax), less the applicable Co-payment.
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Exclusions and Limitations

In addition to the provisions of the Policy titled "Medical Exclusions" and "General Limitations, the following will apply to Prescription Drug Benefits:

No Prescription Drug Benefits are payable for:

- Drugs for Infertility treatment;
- Drugs given while Confined in a Hospital, nursing home or similar place that has its own drug dispensary
- Therapeutic devices or appliances, including colostomy supplies and support garments, regardless of intended use. (This exclusion does not apply to insulin syringes with needles, blood testing strips - glucose, urine testing strips - glucose, ketone testing strips and tablets, lancets and lancet devices which are covered.)
- Injectable drugs (This exclusion does not apply to insulin or self-administered injectables which can be injected subcutaneously which are covered.);
- Progesterone suppositories;
- Appetite suppressants and other weight loss products;
- General and injectable vitamins (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered.);
- Drugs dispensed in any amount which exceed the supply limits;
- Replacement drugs resulting from a lost, stolen, broken or destroyed Prescription Order or Refill;
- Unit dose packaging of drugs;
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug;
- Drugs for tobacco dependency or smoking cessation.
- Drugs for, or in connection with cosmetic surgery unless the Insured Person is injured as a result of an accident that occurs while he or she is covered for Medical Benefits under the Policy, which results in damage to his or her person requiring the cosmetic surgery

Extension of Medical Benefits.

Covered Medical Expenses incurred after termination of an Insured Person's Medical Benefits will be considered Covered Medical Expenses incurred while that insurance is in force, provided: (a) they are incurred prior to the end of the three month period immediately following the date on which that insurance terminated; and (b) they result either from an Injury or a Sickness which causes the Insured Person to be Totally Disabled continuously from the day his or her insurance terminates until the day the Covered Medical Expenses are incurred.

However, the Extension of Medical Benefits will cease to apply to a person as of the date he or she becomes insured for medical care benefits provided under another group insurance plan or under any other arrangement of coverage for individuals in a group.

Medical Exclusions

Covered Medical Expenses will not include, and no payment will be made for expenses incurred:

1. for services or supplies to the extent that benefits are available for the services or supplies elsewhere under the Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the Participating Employer contributes or makes payroll deductions whether or not an Insured Person is covered for such benefits;

2. for services or supplies for which benefits are not payable because of deductible or co-payment provisions under the Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the Participating Employer contributes or makes payroll deductions;

3. for, or in connection with cosmetic surgery unless the Insured Person is injured as a result of an accident that occurs while he or she is covered for Medical Benefits under the Policy, which results in damage to his or her person requiring the cosmetic surgery;

4. for eyeglasses, hearing aids or examinations for prescription or fitting of eyeglasses or hearing aids unless specifically provided for elsewhere in the Policy; including any surgical procedures which are done primarily to correct a refractive error or hearing loss.

5. for, or in connection with treatment of the teeth or gums unless such expenses are incurred for (a) charges made for or in connection with dental work necessitated by Accidental Injury to natural teeth sustained while the Insured Person is covered for Medical Benefits under the Policy for services provided within 90 days of the accident, or (b) charges made by a Hospital for Room and Board or Miscellaneous Services and Supplies;

6. for which benefits are not payable according to the section of the Policy entitled General Limitations.

DENTAL BENEFITS

Dental Benefits are payable for Covered Dental Expenses incurred by an Insured Person.

Dental Benefits are determined this way:

1 subtract any Dental Deductible from Covered Dental Expense; and
2. multiply the result by the Percentage Payable.

Dental Deductible(s)

Individual Dental Deductible

The Individual Dental Deductible applies to each Insured Person. It is a dollar amount of Covered Dental Expense that must be met once each calendar year before benefits are payable for Dental Services.

Family Dental Deductible

If the sum of Covered Dental Expenses used toward an Employee's and his or her Dependents' individual Dental Deductibles in a calendar year equals the Family Dental Deductible, the Individual Dental Deductible will be deemed to be met with respect to Covered Dental Expenses incurred by all Insured Persons in that family for the rest of that calendar year.

The Individual Dental Deductible and the Family Dental Deductible are shown in the Schedule of Benefits.

Percentage Payable

Dental Benefits are paid at percentages of Covered Dental Expenses incurred. These percentages are called the "Percentage Payable". Where the Percentage Payable is less than 100%, the Insured Person is responsible for the difference. The Percentage Payable is shown in the Schedule of Benefits.

Covered Dental Expenses

Covered Dental Expenses are the Reasonable and Customary Charges for Dental Services. This amount will not exceed the actual charge. Covered Dental Expenses must be incurred while insured. Dental Services means those services listed in Parts I, II or III of the Schedule of Dental Services. Such services must be done by or under the direction of a Dentist and must be: (a) required for the treatment or management of the dental condition; (b) commonly and customarily recognized by Dentists as appropriate in the treatment or management of the dental condition (as determined by the ADA or other recognized dental boards); (c) other than educational or experimental; (d) not primarily for the comfort or convenience of the Dentist or Insured Person; and (e) given in the most cost efficient setting consistent with maintaining high quality care.

Date Incurred

The date Covered Dental Expenses are incurred will be:

1. for full or partial dentures, on the date the final impression is taken;
2. for fixed bridges, crowns, inlays and onlays, on the date the teeth are first prepared;
3. for root canal therapy, on the later of: (a) the date the pulp chamber is opened; or (b) the date the canals are explored to the apex;
4. for periodontal surgery, on the date the surgery is actually performed;
5. for all other services, on the date the service is performed.

Calendar Year Maximum Benefit

The Calendar Year Maximum Benefit is the total of benefits payable for Covered Dental Expense incurred by an Insured Person in a calendar year. It is shown in the Schedule of Benefits

Late Entrants

Dental Benefits for an Insured Person who is a Late Entrant will be limited to the following:

(1) Only Part I services during the first six months the person is covered; and
(2) Only Part I and Part II services during the second six months the person is covered.

If an Insured Person who is a Late Entrant suffers a Covered Dental Injury more than 90 days after becoming covered under this plan, benefits will be payable for Covered Dental Expenses incurred as a result of such Injury, as if the person were not a Late Entrant.

Schedule of Dental Services

The following is a list of Dental Services that will be considered for payment.

A temporary Dental Service will be considered a part of the final Dental Service.

SCHEDULE OF DENTAL SERVICES
PART I - PREVENTIVE

PROCEDURE	**LIMITATIONS**
Oral Examination	Limited to twice in any one year period.
Emergency Oral Examination	
Complete Mouth Survey or Panoramic X-ray	Limited to once in any three year period. Includes bitewings and 10 to 14 periapical X-rays.
Individual Periapical X-rays	
Occlusal X-rays	Limited to once in any one year period
Extraoral X-rays	Limited to once in any one year period
Bitewing X-rays	Limited to twice in any one year period.
Other X-rays	
Bacteriologic Cultures	
Dental Prophylaxis	Limited to twice in any one year period.
Fluoride Treatments	Limited to twice in any one year period. Limited to children under the age of 16.

SCHEDULE OF DENTAL SERVICES
PART I - PREVENTIVE
(Continued)

Space Maintainers	Limited to children under the age of 16.
Biopsy	
Palliative Treatment	Paid as a separate benefit only if no other service is rendered during the visit, except X-rays.
Application of Sealants	Limited to one application per tooth in any three year period and only for the first and second permanent molars of Insured Dependent Children under 15 years of age.

SCHEDULE OF DENTAL SERVICES
PART II - BASIC

PROCEDURE	**LIMITATIONS**
Diagnostic Casts	Limited to once in any three year period.
Amalgam Restorations	Multiple restorations on one surface will be paid as a single filling.
Pin Retention	Covered only in conjunction with an amalgam or composite restoration.
Silicate Restorations	
Plastic Restorations	
Composite Restorations	Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.
Re-Cement Inlays	
Re-Cement Crowns	
Crown Build-up	Covered only for endodontically treated teeth which require crowns.
Pulpotomy	
Root Canal Therapy	
Apicoectomy and Retrograde	Paid as a separate benefit only if Filling performed more than 12 months after the root canal therapy is completed.
Hemisection	
Provisional Splinting	

SCHEDULE OF DENTAL SERVICES
PART II - BASIC
(Continued)

PROCEDURE	LIMITATIONS
Occlusal Adjustment	Covered only when performed with Periodontal Surgery or TMJ treatment.
Scaling and Root Planing	Limited to two times per quadrant of the mouth in any one year period.
Periodontal Prophylaxis	Limited to a combined maximum of one prophylaxis in any six consecutive month period including prophylaxis and periodontal prophylaxis.
Relining Dentures	Limited to relining done more than 12 months after the initial insertion, and then not more than once in any two year period.
Tissue Conditioning	
Repairs to Full Dentures, Partial Dentures, and Bridges	Limited to repairs or adjustments performed more than 12 months after the initial insertion.
Repairs to Crowns	
Re-Cement Bridges	
Simple Extraction	
Surgical Extraction Including Extraction of Impacted Teeth	
Root Recovery	
Excision of Pericoronal Tissues	
Incision and Drainage	
General Anesthesia	Will be paid as a separate benefit only when required for complex oral surgical procedures, provided such procedures are otherwise covered under the Policy.
Therapeutic Drug Injections	

SCHEDULE OF DENTAL SERVICES
PART III - MAJOR

All benefits for the services listed below include an allowance for all temporary restorations and appliances.

PROCEDURE	LIMITATIONS
Gold Inlays and Onlays	Covered only when the tooth cannot be restored by a filling, and then only if more than five years has elapsed since the last placement.
Porcelain Restorations	
Crowns	Covered only when the tooth cannot be restored by a filling, and then only if more than five years has elapsed since the last placement. For Insured Persons under 16 years of age, benefits are limited to Plastic or Stainless Steel Crowns.
Stainless Steel Crowns	Covered only when the tooth cannot be restored by a filling.
Post and Core	Covered only for endodontically treated teeth requiring crowns.
Gingivectomy *	
Gingival Curettage *	
Mucogingival Surgery *	
Osseous Surgery *	

* Only one of these surgical procedures per area of the mouth is covered in any one year period.

Osseous Grafts	
Pedicle Grafts	
Free Soft Tissue Grafts	
Vestibuloplasty	
Periodontal Appliance	Limited to one appliance in any one year period.
Full Dentures	There are no additional benefits for overdentures or customized dentures.
Partial Dentures	A partial denture includes clasps, rests and teeth. There are no additional benefits for precision or semi-precision attachments.
Denture Adjustments	Only covered once in any one year period, and only if performed more than 12 months after the insertion of the denture.

SCHEDULE OF DENTAL SERVICES
PART III - MAJOR
(Continued)

PROCEDURE	**LIMITATIONS**
Fixed Bridges	
Maryland Bridge	
Tooth Re-Plantation	
Tooth Transplantation	
Alveoplasty	
Stomatoplasty	
Removal of Exostosis	
Frenectomy (Frenulectomy)	
Excision of Hyperplastic Tissue	

Orthodontics Benefits

Dental Benefits will also include orthodontics *for Insured Dependent Children up to age 19 only*.

Benefits for orthodontics are determined this way:

1. subtract any Orthodontic Deductible from Covered Orthodontic Expenses; and
2. multiply the result by the Percentage Payable for orthodontics.

Covered Orthodontic Expenses

Covered Orthodontic Expenses means the Reasonable and Customary Charges for the following services. This amount will not exceed the actual charge.

1. Cephalometric x-rays.
2. Tooth movement for periodontal purposes.
3. Surgical exposure of impacted teeth.
4. Orthodontic treatment.

Covered Orthodontic Expenses must be incurred while insured under the Policy. Covered Orthodontic Expenses does not include orthodontic expenses if the appliance or bands are inserted before the person becomes insured under the Policy.

Date Incurred

The date all Covered Orthodontic Expenses are incurred will be:

1. the date the bands are inserted;
2. the date the appliance is inserted;
3 the date a procedure is performed, if it's completed on the same day it was started.

Lifetime Orthodontic Maximum

The total amount payable for Covered Orthodontic Expenses during an Insured Person's lifetime will not exceed the Lifetime Orthodontic Maximum shown in the Schedule of Benefits.

Benefit Payments

An orthodontic treatment plan must be submitted to the Insurance Company before benefits are payable for Covered Orthodontic Expense. Total benefits for the course of treatment will then be determined and divided into monthly benefits as follows:

1. Single Charge Basis: If the orthodontic treatment plan does not show a separate charge for appliance insertion, each monthly benefit will be the total benefit pro-rated over the number of months in the treatment plan.

2. Itemized Charge Basis: If the orthodontic treatment plan includes a separate charge for appliance insertion, the benefit for the first month of treatment will not exceed 25% of the total benefit. Subsequent monthly benefits will then be the balance of the total benefit pro-rated over the number of months remaining in the treatment plan.

The Insurance Company will notify the Insured Person and his or her Dentist of the benefits payable.

Orthodontics Benefits (continued)

Benefit Payments

The Insurance Company has the right to require additional information to determine benefits payable. This includes but is not limited to:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models;
4. completion of a questionnaire that will specify: (a) the degree of overjet, overbite, crowding, or open bite; (b) if teeth are impacted, in crossbite, or congenitally missing; (c) the length of treatment; and (d) the total charge for the treatment.

Late Entrants

A person who is a Late Entrant will not be eligible for Orthodontic Benefits for the first 24 consecutive months he or she is covered under the Policy.

Benefits After Attainment of the Dependent Child Limiting Age

Benefits will continue to be payable for an Insured Person who attains the Dependent Child limiting age, provided:

1. the appliance or bands were inserted while the person was under the limiting age, and covered under the Policy; and
2. he or she otherwise remains eligible for coverage; and
3. orthodontic treatment continues.

DENTAL EXCLUSIONS

Covered Dental Expenses will not include, and Dental Benefits will not be payable for, the following charges:

1. charges for crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
2. charges for procedures relating to the change of vertical dimension; restoration of occlusion; bite registration; bite analysis; or which are cosmetic in nature;
3. charges for initial placement of full dentures, partial dentures or bridges if it includes the replacement of teeth all of which were missing on the date the Insured Person became covered under this plan. This exception will not apply if the prosthesis replaces a functioning tooth that was removed while covered;
4. charges for replacement of bridges, partial dentures, full dentures, inlays and crowns unless on the date of the replacement: (a) the Insured Person has been covered under the Policy for at least 12 consecutive months; and (b) it has been at least five years since the bridge, denture, inlay or crown was first inserted. This exception will not apply if the replacement is made necessary by: (i) the removal of a functioning natural tooth; or (ii) Covered Dental Injury to sound natural teeth; provided the removal or Injury occurred during the 12 months preceding the replacement;
5. charges for replacement of bridges, partial dentures, full dentures, crowns or inlays if they can be repaired;
6. charges for implants and related services;
7. charges for orthodontic treatment unless otherwise provided in a section of the Policy entitled "Orthodontics Benefits";
8. charges for appointments which are broken or otherwise missed;
9. for which benefits are not payable according to the section of the Policy entitled "General Limitations".

VISION CARE BENEFITS

If an Insured Person incurs covered vision care expense, the following benefits are payable.

Covered Vision Care Expenses

Covered Vision Care Expenses are the Reasonable and Customary Charges for each of the services or supplies listed in the Schedule of Vision Care Services and Supplies. Benefits are payable up to the Maximum Allowance that applies to each service or supply. Such services or supplies must be rendered by or recommended and approved by an ophthalmologist or optometrist. The Schedule of Vision Care Services and Supplies and the Maximum Allowances are shown in the Schedule of Benefits.

Vision Care Exclusions

No benefits are payable for:

1. charges for more than one examination in any 12 consecutive month period;
2. charges for more than one pair of lenses in any 12 consecutive month period;
3. charges for more than one set of frames in any 12 consecutive month period;
4. charges for sunglasses, unless prescribed to be worn at substantially all times;
5. charges for examinations required by an Employer in connection with employment;
6. charges for any item or service not listed in the Schedule of Vision Care Services and Supplies;
7. charges for services or supplies to the extent that benefits are payable for the services or supplies elsewhere under the Policy;
8. charges for which benefits are not payable according to the section of the Policy entitled "General Limitations".

GENERAL LIMITATIONS

No benefits will be payable under the Policy for any of the following:

1. charges incurred for, or in connection with an Injury arising out of, or in the course of, any employment for wage or profit, including self-employment;
2. charges incurred for, or in connection with a Sickness for which Insured Person is entitled to benefits under any worker's compensation or similar law;
3. charges for care or treatment of any Sickness or Injury that results from war, declared or undeclared, or any act of war, or committing or attempting to commit an assault or felony or from any intentionally self-inflicted Injury;
4. charges incurred for treatment to the extent that payment under the Policy is prohibited by any law of the jurisdiction in which the Insured Person resides at the time the expenses are incurred;
5. charges which the Insured Person is not legally required to pay or for charges which would not have been made if no insurance coverage had existed;
6. charges for services and supplies which are in excess of the lesser of: (a) the Reasonable and Customary Charge; or (b) the actual charge;
7. charges for services and supplies that are not Medically Necessary;
8. charges for vitamins or food supplements or for experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances;
9. charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
10. charges for treatment, services or supplies received in a Hospital owned and operated by any government;
11. charges for private duty nursing services in a Hospital or any other facility;
12. charges in connection with a change in gender;
13. charges incurred by an Insured Person as an organ donor;
14. charges incurred for, or in connection with Custodial Care, education or training;
15. to the extent that the Insured Person is reimbursed, entitled to reimbursement, or is in any way indemnified for those expenses by or through any public program. For the purpose of this paragraph, any individual who, at any time, was entitled to enroll in all or any portion of the medical care program under Title XVIII of the Social Security Act of 1965, as amended (Medicare) but who did not so enroll will be considered to be entitled to reimbursement in an amount equal to the amount to which he or she would have been entitled, if any, if he or she were so enrolled;
16. charges for services rendered by a member of the Insured Person’s Immediate Family;
17. charges for a surgical procedure that does not correct the condition of Infertility but is used to induce Pregnancy, such as in-vitro fertilization, artificial insemination or similar procedure; or
18. charges for reversal of a voluntary surgical sterilization (charges for voluntary surgical sterilizations are covered).

The provision above which indicates that no payment will be made for expenses incurred in connection with Injury arising out of, or in the course of any employment for wage or profit will not apply with respect to any partner, proprietor, or corporate officer who is not himself or herself covered under worker's compensation or similar law.

No payment will be made under the Policy for expenses incurred by an Insured Person to the extent that he or she is reimbursed, entitled to reimbursement or in any way indemnified for those expenses by any personal Injury protection benefits payable under the mandatory portion of any group or individual automobile insurance policy written under the "no-fault" insurance provisions of the law of any jurisdiction.

COORDINATION OF BENEFITS

Applicability. This provision applies to all vision, dental and medical benefits under the Policy

This Coordination of Benefits ("COB") provision applies to This Plan when an Insured Person has coverage under more than one Plan. "Plan" and "This Plan" are defined below under "Definitions."

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the Section entitled "Effect on the Benefits of This Plan".

Definitions

"Plan" means any of these which provides benefits or services for the Insured Person:

1. Group or group-type insurance contracts;
2. Group or group-type subscriber contracts;
3. Uninsured arrangements of group or group-type coverage;
4. Group or group-type coverage through health maintenance organizations and other prepayment, group practice and individual practice plans;
5. The medical benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts; and
6. Coverage under a governmental plan or coverage required or provided by law; but not including: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

However, a Plan does not include school accident-type coverage that covers grammar, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

"Group-type" refers to contracts or coverage's that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts and coverage's answering this description are included in the definition of a Plan whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket").

Each contract or other arrangement for coverage described above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"This Plan" means the Policy.

"Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the Insured Person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the Insured Person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means a Medically Necessary, Reasonable and Customary item of expense when such item is covered at least in part by one or more Plans covering the Insured Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a plan year. However, it does not include any part of that period of time during which an Insured Person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules, described in the Section entitled "Rules" below, require that This Plan's benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The benefits of the Plan which covers the Insured Person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the Insured Person as a Dependent.

Birthday. The Plan which covers an Insured Person as a Dependent of a person whose date of birth occurs earlier in a plan year will pay before the Plan which covers an Insured Person as a Dependent of a person whose date of birth occurs later in a plan year; provided:

1. if the other Plan does not have this rule, its alternate rule will govern; and
2. in the case of an Insured Dependent Child of divorced or separated parents, the rule set forth in the section titled Divorce/Separation below will apply.

Divorce/Separation. If there is a court decree which establishes financial responsibility for medical, dental or other health care expenses of a child, the Plan which covers child as a Dependent of the parent so responsible will be determined before any other Plan; otherwise:

1. the benefits of the Plan which covers the child as a Dependent of the parent with custody will be determined before the Plan which covers the child as a Dependent of a stepparent or a parent without custody
2. the benefits of the Plan which covers the child as a Dependent of a stepparent will be determined before the Plan which covers the child as a Dependent of a parent without custody.

Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Insured Person for the longer term are determined before those of the Plan which covered that Insured Person for the shorter term, subject to the following exceptions:

Active/Inactive Employee. The benefits of a Plan which covers an Insured Person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers the Insured Person as a laid off or retired Employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage. If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in this order:
1. First, the benefits of a Plan covering the Insured Person as an Employee, member or subscriber;
2. Second, the benefits under the continuation coverage.

If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Effect of Medicare

If the Insured Person is also a Medicare beneficiary:

1. due to end stage renal disease, This Plan will determine benefits without consideration of Medicare benefits for which the Insured Person is eligible during the first 30 months of his or her eligibility for such Medicare benefits; or

2. due to any other condition, or due to attainment of age 65 or 70, This Plan will determine benefits without consideration of Medicare benefits for which the Insured Person is eligible.

Effect on the Benefits of This Plan

When This Section Applies. This Section applies when, in accordance with the Section entitled "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Insurance Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Insurance Company any facts it needs to pay the claim.

Facility of Payment. A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the Insurance Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Insurance Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Insurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence of the event on which the claim is based.

Written notice of claim given by or on behalf of the Insured Employee to the Insurance Company at its Home Office, or to any authorized agent of the Insurance Company, with particulars sufficient to identify the Employee, will be considered notice to the Insurance Company. Failure to give written notice within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as was reasonably possible.

Claim Forms. The Insurance Company, will furnish to person making claim or to the Participating Employer for delivery to such person, the claim forms which it usually furnishes for filing proofs of loss. If such forms are not furnished before the expiration of 15 days after the Insurance Company receives notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proofs of Loss. Written proof of loss must be furnished to the Insurance Company at its Home Office within 365 days after the date of the loss for which claim is made. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Insurance Company may reasonably require. Failure to furnish written proof of loss within the time provided in the Policy will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to furnish written proof of loss within that time and that written proof of loss was furnished as soon as was reasonably possible.

Time of Payment of Claims. All benefits payable under the Policy other than benefits for loss of time will be payable no more than 60 days after receipt of proof, and that, subject to proof of loss, all accrued benefits payable under the Policy for loss of time will be paid not less frequently than monthly during the continuance period for which the Insurance Company is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof.

Payment of Claims. Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured Employee. If an Insured Employee dies before all payments due have been made, the amount still payable will be paid to his or her estate.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Insurance Company may make an initial payment, up to an amount not exceeding $5,000 to any relative by blood or connection by marriage of the payee who is deemed by the Insurance Company to be equitably entitled thereto. Such payment does not discharge the Insurance Company's liability for any remaining benefits payable under the Policy.

All or any portion of the Medical, Dental, or Vision Benefits provided by the Policy may, at the option of the Insurance Company, be paid directly to the individual or institution on whose charges claim is based or to any of the following surviving relatives of the Employee: wife, husband, mother, father, child or children, brothers or sisters; or to the executors or administrators of the Employee.

Any payment the Insurance Company makes in good faith fully discharges the Insurance Company's liability to the extent of the payment made.

Direct Payment of Hospital or Medical Services. All or any portion of any indemnities provided by the Policy on account of Hospital, nursing, medical or surgical services may, at the Insurance Company's option, be paid directly to the Hospital or person rendering such cervices, but the Policy may not require that the service be rendered by a particular Hospital or person. Payments so made shall discharge the Insurance Company's obligation with respect to the amount of insurance so paid.

GENERAL PROVISIONS

Legal Actions. No action at law or in equity will be brought to recover on the Policy prior to the expiration of 90 days after written proof of loss has been filed in accordance with the requirements of the Policy, nor will any action be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the Policy.

Time Limitations. If any time limitation provided in the Policy for giving notice of claims, for furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the jurisdiction in which the Employee resides at the time the Policy is issued, then the time limitation of the prevailing jurisdiction applies.

Physical Examination and Autopsy. The Insurance Company, at its own expense, will have the right and opportunity to examine any individual for whom claim is pending under the Policy when and as often as it may reasonably require and to make an autopsy in case of death where it is not forbidden by law.

Reimbursement and Subrogation. When an Insured Person's Injury appears to be someone else's fault, benefits otherwise payable under the Policy for covered expenses incurred as a result of that Injury will not be paid unless the Insured Person or his legal representative agrees:

1. to repay the Insurance Company for such benefits to the extent they are for losses for which compensation is paid to the Insured Person by or on behalf of the person at fault;
2. to allow the Insurance Company a lien on such compensation and to hold such compensation in trust for the Insurance Company; and
3. to execute and give to the Insurance Company any instruments needed to secure the rights under (a) and (b).

Further, when the Insurance Company has paid benefits to or on behalf of the injured Insured Person, the Insurance Company will be subrogated to all rights of recovery that the Insured Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Insurance Company has paid. The Insured Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Insurance Company.

Disclaimer: The Insurance Company is not a healthcare provider and therefore, cannot guarantee any results or outcomes of healthcare treatment you or your eligible dependents may receive or your failure to obtain medical treatment

NOTICE OF FEDERAL REQUIREMENTS

Coverage for Reconstructive Surgery Following Mastectomy

When a person who is insured for benefits under this Certificate and who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your Employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Policy began to provide you with coverage, just as if you never had coverage under the Policy. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs and act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Policy. Your coverage can also be rescinded due to such an act, practice, omission, or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.