HM LIFE INSURANCE COMPANY OF NEW YORK

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

TravelGap Silver

Short Term Medical Plan
Certificate of Coverage

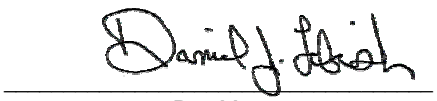
Trip Period Maximum Benefits	**$50,000 per Insured Person**
Period of Insurance Maximum Benefits	**$50,000 per Insured Person**
Repatriation of Remains Maximum Benefit	**Maximum Benefit up to $15,000**
Medical Evacuation Maximum Benefit	**Maximum Benefit up $250,000**
Deductible Plan	**$50 Deductible Plan – Deductible Waived for Hospital and Physician Outpatient Services within HTH International Healthcare Community Providers**

This Plan provides medical benefits while a person is temporarily away from Home.

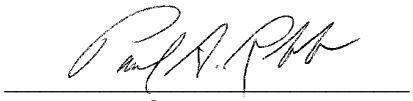
This Plan provides short-term, limited duration coverage. It is not subject to the guaranteed renewability and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Insured Person may not purchase insurance under this Plan for a Period of Insurance longer than 6 months.

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

The Insurance Coverage Area is any place that is anywhere in the world.



President



Secretary

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I. Introduction

About This Plan
This Certificate of Coverage is issued by HM Life Insurance Company of New York ("the Insurer").

In this Plan, the "Insurer" means HM Life Insurance Company of New York. The "Eligible Participant" is the person who meets the eligibility criteria of this Certificate. The term "Insured Person," means the Eligible Participant and any Insured Dependents.

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

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

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

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

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

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

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

Deductible:
The Insured Person's Deductible is $50 per Insured Person per Period of Insurance.

After the Deductible is satisfied benefits are paid for Covered Expenses as follows:

BENEFIT OVERVIEW MATRIX

Benefits	Insurer pays after Medical Benefit Deductible is Paid
Professional Services* a. Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab	100%
b. Office Visits: including X-rays and lab work billed by the attending physician.	100%
Inpatient Hospital Services	
a. Surgery, X-rays, In-hospital doctor visits	100%
b. In-patient medical emergency	100%
Ambulatory Surgical Center	100%
Ambulance Service (non Medical Evacuation)	100% up to $1,000 Maximum per Trip Period
Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor)	Limited to a Maximum of $10,000 per Trip Period
Medical treatment received in the Home Country , if NOT covered by Other Plan**	100% of Covered Expenses up to $2,500 maximum per Trip Period
In the U.S. Outpatient prescription drugs	Not Covered
Outside the U.S. Outpatient prescription drugs	100% of Covered Expenses
Dental Care required due to an Injury	100% of Covered Expenses up to $200 with maximum per Trip Period and $200 per tooth
Dental Care for Relief of Pain	100% of Covered Expenses up to $100 per Trip Period and $100 per tooth
Repatriation Of Remains	Deductible is not applicable. Maximum Benefit up to $15,000
Medical Evacuation	Deductible is not applicable. Maximum Benefit per Period of Insurance for all Evacuations up to $250,000
Bedside Visit	Deductible is not applicable. Maximum Benefit per Period of Insurance up to $1,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person

* If these services are performed by a Provider participating in the HTH International Healthcare Community, the Deductible is waived.

** Same provisions apply for Professional Services, In Patient Hospital Services and Ambulatory Surgical Centers, if the HTH International Healthcare Community providers are used.

II. Who is eligible for coverage?

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

Who is Eligible to Enroll under This Plan? An Eligible Participant:

1. Is a member or employee of a Group covered under the Policy.
2. Has submitted an enrollment form, if applicable, and the premium to the Insurer.
3. Is a bona fide member in good-standing of a membership Group.

Eligible Dependents

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

1. spouse;
2. unmarried natural child, stepchild or legally adopted child who has not yet reached age 19;
3. own or spouse's own unmarried child, of any age, enrolled prior to age 19, who is incapable of self support due to continuing mental retardation or physical disability and who is chiefly dependent on the Eligible Participant. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's 19th birthday and annually thereafter;
4. unmarried child, from their 19th to their 22nd birthday who is a full-time student attending an accredited college, university, vocational or technical school, and who is fully dependent upon the Eligible Participant for support. The Insurer may require proof of student status, but not more than once a Period of Insurance;
5. For a person who becomes an Eligible Dependent (as described below) after the date the Eligible Participant's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:
   a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
   b. Adopted Children: An Insured Participant's adopted child is automatically covered for Illness or Injury for 31 days from either date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. To continue coverage beyond 31 days, as Insured Participant must enroll the adopted child within 31 days either from the date of placement or the final decree of adoption.
   c. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is spouse or minor child, coverage will be automatic for the first 31 days following the date which the court order is issued. To continue coverage beyond 31 days, and Insured Participant must enroll the Eligible Dependent within that 31 day period.
6. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

   The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

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

Additional Requirements for an Eligible Participant and Eligible Dependents: An Eligible Participant or an Eligible Dependent must meet all of the following requirements:

1. a resident of the U.S.
2. under Age 85
3. Enrolled in a Primary Plan.

Application and Effective Dates

The Coverage for an Eligible Participant and his or her Eligible Dependents will become effective if the Eligible Participant submits a properly completed application to the Insurer, is approved for coverage by the Insurer, and the Group and/or the Eligible Participant pays the Insurer the premium. The Effective Date of the Coverage under the Plan is indicated as follows:

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

1. The Policy Effective Date;
2. 12:00:01am on the date or the postmark of the enrollment received by the Insurer;
3. 12:00:01 am on the date designated by the Eligible Participant in the enrollment form, if that date is after the Insurer receives the enrollment form.
4. 12:00:01 am on the date designated by the Group of which the Eligible Participant is a member.

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

1. For a scheduled trip to a Foreign Country, when the Insured Person boards a conveyance at the start of the trip.
2. For any other trip, when the Insured Person is more than 200 miles from his/her Home. Notwithstanding the foregoing, no coverage is in effect for a trip unless the Insured Person is scheduled to spend at least 24 hours away from Home.

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

All applications, if applicable, must be approved by the Insurer for coverage to go into effect.

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

How Period of Insurance Coverage Ends

Insured Persons

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

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

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

1. For a scheduled trip to a Foreign Country, when the Insured Person alights from a conveyance at the completion of the trip.
2. For any other trip, when the Insured Person is less than 200 miles from his/her Home.
3. On the Period of Insurance Termination Date. However, if the Insured Person has not canceled his/her coverage, then coverage for a trip will extend past the Period of Insurance Termination Date if the Insured Person's return is delayed by unforeseeable circumstances beyond his/her control. In this event, coverage will terminate as stated immediately above or, if earlier, 11:59 p.m. on the seventh day following the Period of Insurance Termination Date.
4. If the Insured Person is covered under the Medical Evacuation Benefit, upon the Insured Person's evacuation to his/her Home Area**.**

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

Maximum Trip Coverage Period: Coverage for any one trip may not exceed **70** days.

Group and Insurer

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

The Policy may be terminated by the Insurer:

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

Extension of Benefits

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

III. Definitions

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

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

Age means the Insured Person's attained age.

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

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

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

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

A **Continuing Hospital Confinement** means consecutive days of in-hospital service received as an inpatient, or successive confinements for the same diagnosis, when discharge from and readmission to the Hospital occurs within 24 hours.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of Physicians. It must:

1. be licensed as a hospital and operated pursuant to law; and
2. be primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
4. be an institution which maintains and operates a minimum of five beds; and
5. have X-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, those primarily affording custodial care or educational care.

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

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

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

Injury (See Accidental Injury).

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

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

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Plan.

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

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

Investigative Procedures (See Experimental/Investigational).

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

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

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

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the folbwing three specific services are provided:
1. History (gathering of information on an Illness or Injury).
2. Examination.
3. Medical Decision Making (the Physician's diagnosis and Plan of treatment).

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

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

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

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

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

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

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

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

Pre-existing Condition means a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months immediately preceding the Insured Person's Effective Date of Coverage.

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

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

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

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery).

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

Totally Disabled or Total Disability means:

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

The patient must be under the care of a Physician.

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

U.S. means the United States of America.

IV. How the Plan Works

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

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

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

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

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

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

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

Exception: If Medicare is the primary payer, Covered Expense does not include any charge:
1. By a Hospital in excess of the approved amount as determined by Medicare; or
2. By a Physician or other provider, in excess of the lesser of the maximum Covered Expense stated above; or
    a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
    b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

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

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

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

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

Period of Insurance Deductible
The Insured Person's Period of Insurance Deductible is $50 for each Insured Person per Period of Insurance. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received.

Plan Payment
After the Insured Participant satisfies any required Deductible, payment of Covered Expenses is provided as defined below**:**

Limited Benefits
Regardless of the Insured Person's Out-of-Pocket Maximum, the Insurer pays:
1. For Ambulance Service (non Medical Evacuation), 100% up to $1,000;
2. Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor) that are Limited to $10,000;
3. For Medical treatment received in the Home Country, if NOT covered by Other Plan 100% of Covered Expenses up to $2,500 maximum per Trip Period;
4. Dental Care required due to an Injury, 100% of Covered Expenses up to $200 with maximum per Trip Period and $200 per tooth;
5. Dental Care for Relief of Pain 100% of Covered Expenses up to $100 per Trip Period and $100 per tooth.

For all other Covered Expenses

First Level Payment.
Until an Insured Person satisfies his/her Out-of-Pocket Maximum for the Period of Insurance, the Insurer pays:
1. 100% of the Reasonable Charge for Covered Expense for Office Visits.
2. 100% of the Reasonable Charge for the Covered Expense for all other Covered Services. The Insured Person pays 0% of the Covered Expense, plus any amount in excess of the Covered Expense and in excess of the Reasonable Charge for the Covered Expense.

Period of Insurance Maximum Benefits
The combined total of all medical benefits paid to the Eligible Participant or any Insured Dependent is limited to a maximum of $50,000 per Insured Person during each Insured Person's Period of Insurance, so long as the Insured Participant or the Insured Dependent remains insured under this Plan.

Trip Coverage Period Maximum Benefits
The combined total of all medical benefits paid to the Eligible Participant or any Insured Dependent is limited to a maximum of $50,000 during each Trip Coverage Period for each Insured Person, so long as the Insured Participant or the Insured Dependent remains insured under this Plan and so long as the cumulative amount of paid benefits for all Trip Coverage Periods within the Period of Insurance does not exceed the Period of Insurance Maximum.

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

V. Benefits: What the Plan Pays

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

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

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

Services and Supplies Provided by a Hospital

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

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

Payment of Inpatient Covered Expenses are subject to these conditions:

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

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

Professional and Other Services

The Insurer will pay Covered Expenses for:

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

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

Ambulance Services

The following ambulance services are covered under this Plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Bedside Visit Benefit

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

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

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

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

Excluded Services

The Plan does not provide benefits for:

1. Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Plan.
2. Services **not specifically listed** in this Plan as Covered Services.
3. Services or supplies that are **not Medically Necessary** as defined by the Insurer.
4. Services or supplies that the Insurer considers to be **Experimental or Investigative.**
5. Services received **before the Effective Date** of coverage or during an inpatient stay that began before that Effective Date of Coverage.
6. Services received **after coverage ends** unless an extension of benefits applies as specifically stated under Extension of Benefits in the 'Who is Eligible for Coverage' section of this Plan.
7. Services for which the Insured Person has **no legal obligation to pay** or for which no charge would be made if he/she did not have a health policy or insurance coverage.
8. Services for any condition **for which benefits are recovered or can be recovered**, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
9. Treatment or medical services required **while traveling against the advice of a Physician**, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
10. Services related to **pregnancy or maternity** care other than for complications of pregnancy that may arise during a Trip Coverage Period.
11. Conditions caused by or contributed by (a) **an act of war;** (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) An Insured Person participating in the **military service** of any country; (d) An Insured Person participating in an **insurrection, rebellion, or riot**; (e) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a **felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation;** (f) An Insured Person, age 19 or older, being under the **influence of alcohol or intoxicants or of illegal narcotics** or non-prescribed controlled substances unless administered on the advice of a Physician.
12. Any services provided by a local, state or federal **government agency** except when payment under this Plan is expressly required by federal or state law.
13. Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is **related to the Insured Person** by blood, marriage or adoption, or the Insured Person's employer.
14. Inpatient or outpatient services of a **private duty nurse.**
15. Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
16. Inpatient room and board charges in connection with a Hospital stay primarily for **diagnostic tests** which could have been performed safely on an outpatient basis.
17. Treatment of **Mental, Emotional of Functional Nervous Conditions or Disorders.**
18. Treatment of **Drug, alcohol, or other substance addiction or abuse**.
19. **Dental services,** dentures, bridges, crowns, caps or other dental prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically stated under Dental Care and/or Dental Care for Accidental Injury in the Benefits section of this Plan.
20. Dental and orthodontic services for Temporomandibular Joint Dysfunction (**TMJ**).
21. **Orthodontic Services,** braces and other orthodontic appliances**.**
22. **Dental Implants:** Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
23. **Hearing aids.**
24. Routine **hearing tests.**
25. **Optometric services,** eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.
26. An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
27. Outpatient **speech therapy**.
28. Any **Drugs**, medications, or other substances except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.
29. Any intentionally **self-inflicted Injury or Illness**. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
30. **Cosmetic surgery** or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or to Medically Necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.

31. Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**.
32. Treatment of **sexual dysfunction** or inadequacy.
33. All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization
34. All **contraceptive** services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures.
35. **Cryopreservation** of sperm or eggs.
36. **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.
37. Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method of treatment.
38. **Routine physical exams** or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority.
39. Charges by a provider for **telephone consultations.**
40. Items which are furnished primarily for the Eligible Participant's **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc.).
41. **Educational services** except as specifically provided or arranged by the Insurer.
42. **Nutritional counseling** or food supplements.
43. **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Plan. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings.
44. **Physical and/or Occupational Therapy/Medicine,** except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.
45. All i**nfusion therapy** together with any associated supplies, Drugs or professional services are excluded.
46. **Growth Hormone Treatment.**
47. Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet.
48. **Charges for which the Insurer are unable to determine the Insurer's liability** because the Eligible Participant or an Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize the Insurer to receive all the medical records and information the Insurer requested; or (b) provide the Insurer with information the Insurer requested regarding the circumstances of the claim or other insurance coverage.
49. Charges for the services of a **standby Physician.**
50. Charges for **animal to human organ transplants.**
51. Under the medical treatment benefits, for loss due to or arising from a motor vehicle Accident if the Insured Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
52. Medical treatment, services, supplies, or Confinement in a Hospital owned or operated by **a national government** or its agencies. (This exclusion does not apply to charges the law requires the Insured Person to pay.)
53. Claims arising from loss due to riding in any **aircraft** except one licensed for the transportation of passengers.
54. Claims arising from participation in interscholastic or professional and/or non-professional club **sports or sports event** or participation in mountaineering, motor racing, speed contests, skydiving, hang gliding, parachuting, spelunking, heliskiing, extreme skiing or bungee cord jumping.
55. Treatment for or arising from **sexually transmittable diseases**. (This exclusion does not apply to HIV, AIDS, ARC or any derivative or variation.)
56. Under the **Repatriation of Remains Benefit and the Medical Evacuation Benefit provision**, for repatriation of remains or medical evacuation of the Covered Accident in the U.S.
57. Treatment of **Congenital Conditions**.

NOTE: Creditable Coverage does not apply to this short term policy.

VII. General Provisions

Third Party Liability

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

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

Benefits for Medicare Eligible Insured Persons

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

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

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

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

Alternate Cost Containment Provision

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

Terms of the Insured Participant's Plan

1. **Entire Contract and Changes**: The entire contract between the Group and the Insurer is as stated in the Policy and the entire contract between the Insured Participant and the Insurer is as stated in the Certificate of Coverage including the endorsements, application, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of the Insurer's officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.

2. **Payment of Premiums:** Premiums are payable in advance. Premiums must be paid monthly including any contributions the Insured Participant must make. The Insurer may change the premium rates from time to time. The Insurer must give the Group written notice of any premium rate change at least 30 days prior to the change. The Insurer may not increase premiums without first providing written notification to the Group at least 30 days prior to the date the increase is to take effect, with the exception of retroactive premium rate increases related to fraud or the intentional misrepresentation of a material fact.

3. **Grace Period:** There is a Grace Period of 31 days allowed for the payment of each premium after the first premium.

4. **Representations:** All statements made by the Insured Participant or the Group shall be considered representations and not warranties. The Insurer must provide the Insured Participant or the Group with a copy of any statements used to contest coverage.

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

   The above does not apply to fraudulent misstatements.

6. **Legal Actions:** The Insured Person cannot file a lawsuit before 60 days after the Insurer has been given written proof of loss. No action can be brought after 3 years from the time that proof is required to be given.

7. **Conformity With State Statutes:** If any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Policyholder resides, it is amended to conform to the minimum requirements of those statutes.

8. **Provision in Event of Partial Invalidity:** If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

9. **The Claims Process**

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

   Within 15 days after the Insurer receive the Insured Person's written notice of claim, the Insurer must:
   a. acknowledge receipt of the claim;
   b. begin any investigation of the claim;
   c. specify the information the Eligible Participant must provide to file proof of loss. (The Insurer can request additional information during the investigation if necessary.)
   d. send the Insured Person any forms the Insurer require for filing proof of loss. If the Insurer does not send the forms within this time period, the Insured Person can file proof of loss by giving the Insurer a letter describing the occurrence, the nature and the extent of the Insured Person's claim. The Insured Person must give the Insurer this letter within the time period for filing proof of loss.

   Proof of Loss: Within 90 days after the Insured Person receives Covered Services, he/she must send the Insurer written proof of loss. If it is not reasonably possible to give the Insurer written proof in the time required, the Insurer will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to the Insurer no later than one year from the date otherwise required.

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

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

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

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

   Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:
   1. It is duly executed on a form acceptable to the Insurer; and
   2. A copy is on file with the Insurer.

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

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

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

10. **Misstatement of Age:** If the age of an Insured Person has been misstated, an adjustment of premiums shall be made based on the Insured Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

11. **Right to Recovery:** If the Insurer makes benefit payments in excess of the benefits payable under the provisions of the Plan, the Insurer has the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.

12. **Plan Administrator – COBRA and ERISA.** In no event will the Insurer be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than the Insurer, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Eligible Participant's agent.

13. **Waiver of Rights:** Failure by the Insurer to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

14. **Physical Exam and Autopsy:** The Insurer has the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Insured Participant will not have to pay for it.

15. **Required Information:** The Group will furnish the Insurer all information necessary to calculate the Premium and all other information that the Insurer may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. The Insurer have the right to examine any records of the Group, any person, company or organization which may effect the Premiums and benefits of the Plan.

    The Insurer's right to examine any records exists:
    1. During the time the Plan is in force; or
    2. Until the Insurer pay the last claim.

The Insurer is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Ambulatory Surgical Center, skilled nursing facility, or from any Provider. Such facilities are providers act as independent contractors and not as employees, agents or representatives of the Insurer.

The Insurer is entitled to receive from any provider of service information about the Insured Person which is necessary to administer claims on the Insured Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Insured Participant has authorized every provider furnishing care to disclose all facts pertaining to the Insured Participant's and his/her Insured Dependent's care, treatment, and physical condition, upon the Insurer's request. The Insured Participant agrees to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services.

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

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

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

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

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

HM Life Insurance Company of New York
420 Fifth Avenue, 3rd Floor
New York, NY 10018

Dispute Resolution

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

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

HM LIFE INSURANCE COMPANY OF NEW YORK

420 Fifth Avenue, New York New York 10018
1-800-328-5433
Administrative Office: One Radnor Corporate Center, Suite 100, Radnor, Pennsylvania 19087

Endorsement to Policy/Certificate

State of New York

This Endorsement is made part of the policy/certificate to which it is attached as of the effective date of such Policy/Certificate.

By attachment of this Endorsement, it is understood and agreed that the insurance under the Policy/Certificate is amended as follows:

1. Page One of the Certificate form is amended to remove the Optional Paragraph regarding Excess Coverage.

2. The optional "Additional Requirements for an Eligible Participant…" provision within Section II, "Who is Eligible for Coverage," is amended to remove all residency requirements.

3. The "How Period of Insurance Coverage Ends" provision within Section II, "Who is Eligible for Coverage," is amended to revise the fourth item as follows:

   4. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision, so long as the fraud or misrepresentation of material fact is contained in a written statement signed by the Insured Person.

4. The "Extension of Benefits" provision within Section II, "Who is Eligible for Coverage," is amended to include the following:

   If the Insurer terminates the Policy, coverage will be extended for a Covered Person who:
   1. Is Totally Disabled on the date coverage ends.

   Coverage under this provision is provided only for Covered Medical Expenses with respect to:
   1. A Totally Disabled Covered Person, for the condition causing the Total Disability.

   Coverage so extended will end on the first of the following to occur:
   1. The 90th day following termination of the Policy; or
   2. The date the Total Disability ends.

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

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

5. The definition of Custodial Care as within Section III, "Definitions," is amended as follows:

   Custodial Care is care provided primarily to meet the Insured Person's personal needs. This includes help in transferring, eating, dressing, bathing, toileting, and other such related activities.

6. The definition of Pre-Existing Condition as within Section III, "Definitions," is amended as follows:

   Pre-existing Condition means a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months immediately preceding the Insured Person's Effective Date of Coverage.

7. Section V, "Benefits: What the Plan Pays" is amended to include the following:

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

   1. **Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Conception must have occurred while the Covered Person was insured under the Policy. An Eligible Participant or an Eligible Dependent, if covered, must be Continuously Insured under the Policy for at least 10 months before this benefit is payable, subject to credit for prior Creditable Coverage, as described in the Pre-Existing Condition Limitation Section. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
      a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
      b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

      If the physician, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's

office, as determined by the physician in consultation with the mother. The post delivery care must be provided within 24 hours after discharge, or of the time of the mother's request. The post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

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

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

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

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

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

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

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

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

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

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

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

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

8. **Diabetes treatment:** Charges for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a Physician or other licensed health care provider legally authorized to prescribe under title eight of the Education Law: blood

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

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

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

10. **Pre-hospital Emergency Medical Services:** Coverage will include expenses incurred for pre hospital Emergency Medical Services (pre-hospital emergency medical services means the prompt evaluation and treatment for an emergency medical condition and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, processing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.)

11. **Bone Density Testing:** Coverage will include expenses incurred for bone mineral density measurements or tests, and if the Policy includes coverage for prescription drugs, coverage will also include Medically Necessary prescription drugs or devices for the detection of osteoporosis. Covered Persons qualifying for this coverage include those:
   (i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
   (ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
   (iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or
   (iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
   (v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

12. **Second Medical Opinion**: Charges for a second medical opinion by an appropriate specialist, including but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer.

13. **Chiropractic Care:** Charges for chiropractic care provided by a Physician, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

14. **End of Life Care**: Charges incurred by a Covered Person who has a life expectancy of six months or less, as certified by the Covered Person's primary Physician, for hospice or acute care services at a hospice or acute care facility licensed pursuant to article twenty-eight of the public health law specializing in the treatment of terminally ill patients if the patient's attending health care practitioner, in consultation with the medical director of the facility determines that the Covered Person's care would appropriately be provided by such a facility.

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

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

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

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

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

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

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

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

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

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

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

17. Additional Benefits as Required by New York Law. Under New York law, certain mandated benefits are required to be provided under a medical expense policy. Coverage will be provided as applicable to this program for such mandates.

8. Section VI, "Exclusions and Limitations: What the Plan Does Not Pay For" is hereby deleted in its entirety and replaced with the following:

VI. Exclusions and Limitations: What the Plan Does Not Pay For

Excluded Services

The Plan does not provide benefits for:

1. Services **not specifically listed** in this Plan as Covered Services.
2. Services received **before the Effective Date of coverage** or during an inpatient stay that began before that Effective Date of Coverage.
3. Services received **after coverage ends** unless an extension of benefits applies as specifically stated under Extension of Benefits in the 'Who is Eligible for Coverage' section of this Plan.
4. Services for which the Insured Person has **no legal obligation to pay** or for which no charge would be made if he/she did not have a health policy or insurance coverage.
5. Services for any condition **for which benefits are provided** under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
6. Conditions caused by or contributed by (a) An Insured Person participating in the Armed Forces, auxiliary units, or **military service** of any country; (b) An Insured Person participating in an **insurrection or riot**; (c) Services received for any condition caused by an Insured Person's **participation in a felony**; d) **war or act of war, whether declared or undeclared.**
7. Any services provided by a **government program** except when payment under this Plan is expressly required by federal or state law.
8. Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is **a member of the Insured's immediate family**.
9. Treatment of **Drug or alcohol addiction**.
10. **Dental services or treatment,** except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly, except as specifically stated under Dental Care and/or Dental Care for Accidental Injury in the Benefits section of this Plan.
11. **Hearing aids.**
12. Routine **hearing tests.**
13. **Optometric services,** eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.
14. Any intentionally **self-inflicted Injury**. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
15. **Cosmetic surgery,** except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. This exclusion also does not apply to Medically Necessary reconstructive surgery performed to restore symmetry or appearance incident to a mastectomy. Coverage and determinations with respect to cosmetic surgery are subject to utilization review and external appeal requirements of New York Law.
16. Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet.
17. **Charges for which the Insurer are unable to determine the Insurer's liability** because the Eligible Participant or an Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize the Insurer to receive all the medical records and information the Insurer requested; or (b) provide the Insurer with information the Insurer requested regarding the circumstances of the claim or other insurance coverage.
18. Medical treatment, services, supplies, or Confinement in a Hospital owned or operated by **a national government** or its agencies. (This exclusion does not apply to charges the law requires the Insured Person to pay.)
19. Claims arising from loss due to riding in any **aircraft** except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

9. Within Section VII, "General Provisions," Number 5, "Time Limit on Certain Defenses/Misstatements on the Application" as within the Terms of the Insured Participant's Plan provision is hereby amended as follows:

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

   The above applies only to statements contained in a written instrument signed by the Insured Person.

   The above does not apply to fraudulent misstatements.

10. Within Section VII, "General Provisions," the Proof of Loss provision is hereby amended as follows:

Proof of Loss: Within 90 days after the Insured Person receives Covered Services, he/she must send the Insurer written proof of loss. If it is not reasonably possible to give the Insurer written proof in the time required, the Insurer will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible.

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

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

11. Within Section VII, "General Provisions," the Grievance Procedures provision is hereby amended as follows:

Grievance Procedures:

Notice of Grievance Procedures to New York Residents

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

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

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

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

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

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

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

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

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

First Level Internal Review: The Covered Person, the Covered Person's attending physician or the Covered Person's personal representative acting on their behalf, may file a written request for first level review within 45 days after the date of receipt of notice of an

adverse determination. At this level, the request will be reviewed by a qualified individual knowledgeable with the matters at issue and at a higher level position than the person who made the initial adverse determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. Within Section VII, "General Provisions," a new item 16, a provision regarding Continuation of Benefits, is added:

16. Coordination of Benefits:

1. Applicability.
   a. This Coordination of Benefits ("COB") provision applies to This Plan when you or your Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
   b. If this COB provision applies, the order of benefits 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: (i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but (ii) may be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. See "Effect on the Benefits of This Plan".
2. Definitions.
   a. A "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
      (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practices or individual practice coverage. It also includes coverage other than school accident-type coverage.
      (2) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any private insurance program or other non-governmental program.

      Each contract or other arrangement for coverage under (1) or (2) 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.
   b. "This Plan" is the part of the group contract that provides benefits for health care expenses.
   c. "Primary Plan"/"Secondary Plan."
      (1) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
      (2) 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.
      (3) 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.
      (4) When there are more than two Plans covering the 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.

d. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

(1) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

(2) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

e. "Claim Determination Period" means a plan Year. However it does not include any part of a year during which a 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.

3. Order of Benefit Determination Rules.

a. 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: (i) the other plan has rules coordinating its benefits with those of This Plan; and (ii) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other Plan.

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

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

(2) Dependent Child/Parents Not Separated or Divorced. When This Plan and another Plan cover the same child as a dependent of different persons, called "parents": (i) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but (ii) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rules described in (i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (i) first, the Plan of the parent with custody of the child; and (ii) then, the Plan of the spouse of the parent with custody of the child; and (iii) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). 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 section is ignored.

(5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. Effect on the Benefits of This Plan.

a. This Section applies when, in accordance with "Order of Benefit Determination Rules" above, this Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan or Plans are referred to as "the other Plans" in b. immediately below.

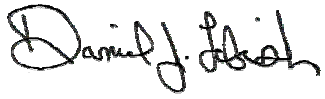
b. The benefits of This Plan will be reduced when the sum of: (i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and (ii) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions 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.

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

6. Facility of Payment. A payment under another Plan may include an amount which should have been paid under This Plan. If it does, we 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. We 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.
7. Right of Recovery. If the amount of the payments made by us is more than it should have paid under this COB provision, we may recover the excess from one or more of:
   a. the persons it has paid or for whom it has paid;
   b. insurance companies; or
   c. other organizations.

   The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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



President