



La Sierra University
 CERTIFICATE OF COVERAGE

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. B-1005-09 ("the Policy")

Participating Organization or Institution: **La Sierra University**

Participating Organization's or Institution's Effective Date: **January 1, 2009**

Eligible Participant: **See Identification Card Issued to Participant**

Eligible Dependents: **See Identification Card Issued to Participant**

Coverage Start Date: **See Identification Card Issued to Participant**

This Certificate refers to an Eligible Participant and an Eligible Dependent as a "Covered Person," and to BC Life & Health Insurance Company as "Insurer." The Policy will be administered on behalf of the Insurer by "the Administrator", Worldwide Services Insurance Agency.

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

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**SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES**

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

- Class I: All regular, full-time Eligible Participants of the educational organization or institution and their Eligible Dependents.
- Class II: All part-time Eligible Participants of the educational organization or institution and their Eligible Dependents.
- Class III: Mandatory - Eligible Participants.
- Class IV: Voluntary - Eligible Dependents - Spouse.
- Class V: Voluntary - Eligible Dependents - Child.

All benefits and limits are stated per Covered Person

SCHEDULE OF BENEFITS – TABLE 1

	Limits Eligible Participant	Limits Spouse	Limits Child
COVERAGE A – MEDICAL EXPENSES			
Lifetime Maximum Benefit	\$1,000,000	\$1,000,000	\$1,000,000
Policy Year Maximum Benefits	\$100,000	\$100,000	\$100,000
Maximum Benefit per Injury or Sicknesses	\$100,000	\$100,000	\$100,000
Policy Year Out-of-Pocket Limit for any one Injury or Sickness Out-of-Pocket Limit means the amount of Reasonable Expenses for which the Covered Person is responsible after which the Insurer pays 100% of the Reasonable Expenses, subject to the limits and provisions of the Policy.	After the Covered Person reaches a \$5,000 Out-of-Pocket Limit per Injury or Sickness per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Co-payments and amounts above the maximums do not apply toward the Out-of-Pocket Limit.	After the Covered Person reaches a \$5,000 Out-of-Pocket Limit per Injury or Sickness per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Co-payments and amounts above the maximums do not apply toward the Out-of-Pocket Limit.	After the Covered Person reaches a \$5,000 Out-of-Pocket Limit per Injury or Sickness per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Co-payments and amounts above the maximums do not apply toward the Out-of-Pocket Limit.
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to \$10,000	Maximum Benefit: Principal Sum up to \$5,000	Maximum Benefit: Principal Sum up to \$1,000
COVERAGE C – REPATRIATION OF REMAINS	Maximum Benefit up to \$15,000	Maximum Benefit up to \$15,000	Maximum Benefit up to \$15,000
COVERAGE D – MEDICAL EVACUATION	Maximum Lifetime Benefit for all Evacuations up to \$50,000	Maximum Lifetime Benefit for all Evacuations up to \$50,000	Maximum Lifetime Benefit for all Evacuations up to \$50,000

**SCHEDULE OF BENEFITS – TABLE 2
COVERAGE A – MEDICAL EXPENSES**

PLEASE READ THE FOLLOWING STATEMENT SO YOU WILL KNOW THAT BENEFITS WILL DIFFER BASED ON THE PROVIDER YOU CHOOSE. If the Schedule of Benefits Table 2 refers to Prudent Buyer Plan, the coverage provided by the policy will differ depending on whether the Covered Person receives care within the Prudent Buyer Plan or outside the Prudent Buyer Plan. Please read the terms of coverage carefully.

	Prudent Buyer Plan Participating Provider Limits	Non-Participating Provider Limits
Physician Office Visits	80% of Negotiated Rates after \$20 Co-payment per visit.	After Deductible or Co-payment, 60% Reasonable Expenses.
Inpatient Hospital Services	80% of Negotiated Rates after \$50 Co-payment per visit.	After Deductible or Co-payment, 60% Reasonable Expenses.
Hospital and Physician Outpatient Services	80% of Negotiated Rates after \$50 Co-payment per visit.	After Deductible or Co-payment, 60% Reasonable Expenses.

If a Covered Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Participating Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Participating Provider.

If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Participating Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Participating Provider.

**SCHEDULE OF BENEFITS – TABLE 3
COVERAGE A – MEDICAL EXPENSE BENEFITS**

BENEFITS LISTED BELOW ARE SUBJECT TO

1. TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;
2. TABLE 2 PLAN TYPE LIMITS

MEDICAL EXPENSE	Limits – Covered Person
Maternity Care for a Covered Pregnancy	Reasonable Expenses
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$5,000 Maximum per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$500 lifetime
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to \$2,500 Maximum per Policy Year on an Inpatient basis
Therapeutic termination of pregnancy	Reasonable Expenses up to \$1,000 Maximum per Policy Year
Medical treatment of Injuries sustained as a result of a covered motor vehicle accident	Reasonable Expenses up to \$10,000 Maximum per Policy
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$500 per Policy Year maximum
Outpatient prescription drugs including oral and Norplant contraceptives	50% of actual charge

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES

A. What the Insurer Pays for Covered Medical Expenses: If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit of \$100,000 per Injury or Sickness for the Eligible Participant or the Maximum Benefit of \$100,000 per Injury or Sickness for an Eligible Dependent. Benefits are subject to the Deductible Amount, Coinsurance and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation and to all other limitations and provisions of the Policy.

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

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

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

If the Covered Person was insured under a group policy previously offered to a Participating Organization or Institution immediately prior to Policy Effective Date of a group policy administered by the Administrator, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance so long as there was continuous coverage from the previous policy to the current policy.

1. **Physician office visits.**

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

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

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

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

- a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
- b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

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

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

Note: This Plan includes the Covered Person's participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the California Department of Health Services.

2. **Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear. (Cervical screenings are not subject to the deductible provision).
3. **Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:
 - a) female Covered Persons are allowed one baseline mammogram;
 - b) female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.);
4. **Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.
5. **Diabetes Supplies/Education:** Coverage shall be provided for the Medically Necessary prescription, equipment and supplies for the management and treatment of insulin using diabetes, non-insulin using diabetes, and gestational diabetes as Medically Necessary (even if the items are available without a prescription):
 - a) Insulin;
 - b) Prescription medications for the treatment of diabetes;
 - c) Glucagon;
 - d) Blood glucose monitors and blood glucose testing strips;
 - e) Blood glucose monitors designed to assist the visually impaired;
 - f) Insulin pumps and all related necessary supplies;
 - g) Ketone urine testing strips;
 - h) Lancets and lancet puncture devices;
 - i) Pen delivery systems for the administration of insulin;
 - j) Podiatric devices to prevent or treat diabetes-related complications;
 - k) Insulin syringes;
 - l) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin;

In addition, coverage shall include diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable a Covered Person to properly use the equipment, supplies, and medications set forth above and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the Covered Person's Physician.

The diabetes outpatient self-management training, education, and medical nutrition therapy services set forth above shall be provided by appropriately licensed or registered health care professionals as prescribed by a health care professional legally authorized to prescribe the services.

6. **Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.
7. **Other Cancer Screening Tests.** Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions.
8. **Cancer Clinical Trials.** A Covered Person diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer will be covered for all routine patient care costs related to the clinical trial if the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Covered Person. For purposes of this benefit, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

"Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Policy if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

- a) Health care services typically provided absent a clinical trial.
- b) Health care services required solely for the provision of the investigational drug, item, device, or service.
- c) Health care services required for the clinically appropriate monitoring of the investigational item or service.
- d) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
- e) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

"Routine patient care costs" do not include the costs associated with the provision of any of the following:

- a) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- b) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that a Covered Person may require as a result of the treatment being provided for purposes of the clinical trial.
- c) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- d) Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the Policy.
- e) Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- f) The treatment shall be provided in a clinical trial that either: (1) involves a drug that is exempt under federal regulations from a new drug application; or (2) that is approved by one of the following:
 - i) One of the National Institutes of Health.
 - ii) The federal Food and Drug Administration, in the form of an investigational new drug application.
 - iii) The United States Department of Defense.
 - iv) The United States Veterans' Administration.

In the case of health care services provided by a Participating Provider, the payment rate shall be at the agreed-upon rate. In the case of a Non-Participating Provider, the payment shall be at the negotiated rate the Insurer would otherwise pay to a Participating Provider for the same services, less applicable Co-payments and deductibles. The Insurer may restrict coverage for clinical trials to Hospitals and Physicians in California unless the protocol for the clinical trial is not provided for at a California Hospital or by a California Physician.

9. **Outpatient Prescription Drugs:** If prescription drugs are covered, such will include FDA approved prescription contraceptives, including injectable and implantable methods administered in a Physician's office.
10. **Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.
11. **Certain Dental Procedures on Children:** Coverage is provided for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting, when the clinical status or underlying medical condition of the Covered Person requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or surgery center setting.

This benefit shall apply only to general anesthesia and associated facility charges and for only the following Covered Persons:

- a) Covered Persons who are under seven years of age.
- b) Covered Persons who are developmentally disabled, regardless of age.
- c) Covered Persons whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

No benefits are payable for the dental procedure itself or the professional fee of the dentist. Coverage for anesthesia and associated facility charges shall be subject to all other terms and conditions of the Policy that apply generally to other benefits.

In addition, no coverage is provided for anesthesia or related facility charges for dental procedures that would ordinarily require general anesthesia, except for those Covered Persons described above.

12. **Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:
 - a) Reconstruction of the breast on which the mastectomy has been performed;
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - c) Prostheses; and
 - d) Treatment for physical complications of all stages of mastectomy, including lymphedemas.

13. **Reconstructive Surgery:** Coverage includes reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to do either of the following:
- To improve function.
 - To create a normal appearance, to the extent possible.

However, this benefit shall not be construed to provide coverage for cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

14. **Laryngectomy; prosthetic devices:** Coverage is provided for prosthetic devices necessary to restore a method of speaking for the Covered Person incident to a laryngectomy. This includes initial and subsequent prosthetic devices including installation accessories pursuant to a Physician's order. (Prosthetic devices do not include electronic voice producing machines);

15. **Osteoporosis:** Coverage shall include services related to diagnosis, treatment, and appropriate management of osteoporosis, including bone mass measurement technologies as deemed medically appropriate.

16. **Phenylketonuria (PKU):** Coverage shall include testing and treatment of phenylketonuria (PKU), including those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who is authorized by the Insurer provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU). Coverage is provided only to the extent that the costs of necessary formulas and special food products exceeds the cost of a normal diet.

17. **Hormone Replacement Therapy:** If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

18. **Severe Mental Illness:** Coverage shall include the diagnosis and Medically Necessary treatment of severe mental illness of a Covered Person of any age, and of serious emotional disturbances of a child, including the following:

- Outpatient services;
- Inpatient hospital services;
- Partial hospital services; and
- Prescription drugs, if the policy includes coverage for prescription drugs.

As used here, "severe mental illness" includes:

- Schizophrenia;
- Schizoaffective disorder;
- Bipolar disorder (manic-depressive illness);
- Major depressive disorders;
- Panic disorder;
- Obsessive-compulsive disorder;
- Pervasive developmental disorder or autism;
- Anorexia nervosa; and
- Bulimia nervosa;

"Serious emotional disturbances of a child" means a child who: (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

19. **Jawbone surgery:** Coverage shall include surgical procedures for those covered conditions directly affecting the upper or lower jawbone, or associated bone joints, if each procedure being considered for reimbursement is deemed Medically Necessary by the Insurer. This benefit will not affect any applicable exclusion pertaining to dental services other than as stated herein.

20. **Second Surgical Opinions and Telemedicine:** The coverage provided under the Policy will include second surgical opinions and Telemedicine services.

SECTION 3
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

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

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

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

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

SECTION 4
COVERAGE C – REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the repatriation of the Covered Person's 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 or visitation or funeral expenses. Any expenses for repatriation of remains require the Insurer's or the Administrator's prior approval.

If an Injury or a Sickness results in the Covered Person's loss of life outside his/her Home Country, the Insurer will pay the Reasonable Expense incurred for cremation or for preparation of the body for burial in, and for transportation of the body to, the Home Country up to the maximum stated for this benefit in Table 1 of the Schedule of Benefits. Payment of this benefit is subject to the Limitations and Conditions on Eligibility for Benefits. No benefit is payable if the death occurs after the Period of Coverage Termination Date. However, if the Covered Person is Hospital Confined on the Period of Coverage Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Period of Coverage Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by either the Insurer or the Administrator before the body is prepared for transportation.

SECTION 5
COVERAGE D – MEDICAL EVACUATION BENEFIT

If a Covered Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to the lifetime Maximum Limit for all medical evacuations shown in Table 1 of the Schedule of Benefits, for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Covered Person's Home Country. Transportation must be by the most direct and economical route. However, before the Insurer makes any payment, it requires written certification by the attending Physician that the evacuation is Medically Necessary. Any expenses for medical evacuation require the Insurer's or the Administrator's prior approval. No benefits are payable under any other provision of the Policy for expense incurred by the Covered Person on and after the date of the evacuation.

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

**SECTION 6
PRE-EXISTING CONDITION LIMITATION**

The Insurer does not pay benefits for loss due to a Pre-Existing Condition during the first 6 months of coverage. Pre-Existing Conditions will be covered after the Covered Person's coverage has been in force for 6 months. This limitation does not apply to a child born to or newly adopted by an enrolled Participant or their spouse, or to conditions of pregnancy. Also, if you were covered under Creditable Coverage, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

As used here, Creditable Coverage means coverage provided under:

- a. a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- b. a group health benefit plan provided by a health insurance carrier or health maintenance organization;
- c. an individual health insurance policy or evidence of coverage;
- d. Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
- e. Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);
- f. Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
- g. A medical program of the Indian Health Service or of a tribal organization;
- h. A state or political subdivision health benefits risk pool;
- i. A health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);
- j. A public health plan as defined by federal regulations;
- k. A health benefit plan under Section 5 (e), Peace Corps Act (22 U.S.C. Section 2504(e)).

This limitation does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.

**SECTION 7
GENERAL POLICY EXCLUSIONS**

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

1. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, including routine care of a newborn infant.
2. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
3. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
4. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
5. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
6. Expenses in excess of Reasonable Expenses.
7. Expenses incurred for Injury resulting from the Covered Person's being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.
8. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.
9. Organ or tissue transplant.
10. Participating in an illegal occupation or committing or attempting to commit a felony.
11. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
12. 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.
13. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
14. Expenses incurred within the Covered Person's Home Country.
15. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, temporomandibular joint (TMJ) dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, except for repairs to sound natural teeth due to an Injury or as specifically stated in "Certain Dental Procedures on Children" and "Jawbone surgery," respectively, in Section 2.
16. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
17. Diagnosis and treatment of acne and sebaceous cyst.
18. Outpatient treatment for specified therapies including, but not limited to, Physiotherapy and acupuncture.
19. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.

20. Self-inflicted Injuries while sane or insane; suicide, or any attempt thereof while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.
21. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion; or acts of terrorism.
22. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
23. Elective termination of pregnancy.
24. Loss arising from participation in professional sports, scuba diving, hang gliding, parachuting or bungee jumping.
25. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
26. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
27. Expenses incurred for treatment of sports-related accidents resulting from interscholastic, intercollegiate, intramural, or club sports.
28. Expenses incurred as a result of pregnancy that is not covered.

SECTION 8 DEFINITIONS

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

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

Age means the Covered Person's attained age.

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

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

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

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

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

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

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

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

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

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

1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, except as stated in the Extension of Benefits provision. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section 3.

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

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

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

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

Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 18 – 25 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption and a child who does not reside with the Participant when the Participant is required to provide group health coverage for the child pursuant to an administrative or court order. The Eligible Dependent is one who:

1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and
2. Is temporarily located outside the Eligible Participant's Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Eligible Participant means a person who:

1. Is engaged in international educational activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care:

1. That is provided for an Injury or a Sickness caused by the sudden, unexpected onset of a medical condition with acute symptoms of sufficient severity and pain to require immediate medical care; and
2. In the absence of which one could reasonably expect that one or more of the following would occur:
 - a. The Covered Person's health would be placed in serious jeopardy.
 - b. There would be serious impairment of the Covered Person's bodily functions.
 - c. There would be serious dysfunction of any of the Covered Person's bodily organs or parts.

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

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

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

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

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

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

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

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Medically Necessary means medical and dental services, treatment or supplies which the Insurer determines to be:

1. Appropriate and necessary for the 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 medical community;
4. Not primarily for your convenience, or for the convenience of your Physician or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - c. For Hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

A medical or dental treatment will not be deemed Medically Necessary if any service, supply or treatment used or provided in connection with the Injury or Sickness is Experimental or Investigational in nature. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary. If services do not meet the criteria above or are not consistent with professionally recognized standards of care with respect to quality, frequency or duration, such services will not be deemed Medically Necessary.

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

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

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

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type. It does not include student accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

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

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

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

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

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

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

Participating Provider means a Hospital, Physician, or other health care provider who has agreed to participate in the Insurer's PPO program which is called the Prudent Buyer Plan.

Preferred Provider Organization (PPO) means the network(s) of Preferred Providers the Insurer calls the Prudent Buyer network.

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received up to 6 months prior to the Covered Person's effective date of coverage.

- Reasonable Expense** means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,
1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
 2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

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

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

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
 - a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
 - b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

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

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

SECTION 9 EXTENSION OF BENEFITS

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

Coverage under this provision is provided only for Covered Medical Expenses with respect to 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 date the Total Disability ends; or
2. The end of the 52 - 104 week period during which expenses must be incurred to receive benefits under the Policy.

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.

SECTION 10 EXCESS COVERAGE

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

SECTION 11 ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

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

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

1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

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

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date shown on the Insurance Identification Card, if any;
4. The date the requirements in Section 1—Eligible Classes are met; or
5. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

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

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

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

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

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

1. The date the Policy terminates;
2. The Participating Organization's or Institution's Termination Date;
3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
4. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
5. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage or if the enrollment form contained inaccurate or misleading information (this will not apply, except for fraudulent statements, after the coverage has been in force for two years from the date the Participant became covered).

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

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

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date of the Eligible Participant's insurance;
4. The effective date shown on the insurance identification card, if any;
5. The date the eligibility requirements in this section are met; or
6. The date the completed enrollment form, if any, and premium are received by the Insurer.

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

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

1. The date the Policy terminates; or
2. The Participating Organization's or Institution's Termination Date;
3. The date the Eligible Participant is no longer covered under the Policy;
4. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;
5. 11:59:59 a.m. on the date he or she departs the Country of Assignment for his or her Home Country;
6. The date the Covered Person requests cancellation of coverage (the request must be in writing);
7. The premium due date for which the required premium has not been paid, or
8. The date on which the dependent ceases to meet the eligibility requirements.

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

**SECTION 12
COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN**

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

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

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

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

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

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

**SECTION 13
CLAIM PROVISIONS**

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

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

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

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

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

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

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

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

SECTION 14 GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

Reimbursement for acts of third parties. Under some circumstances, an Covered Person may need services under this Plan of insurance for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this Plan subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this Plan for the treatment of the illness, disease, injury or condition for which the third party is liable, reduced by the fees and costs associated with the recovery, but, not more than the amount allowed by California Civil Code Section 3040.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require facilitating enforcement of our rights. You must not take action which may prejudice our rights or interests under your Plan. Failure to give us such notice or to cooperate with Us, or actions that prejudice our rights or interests will be a material breach of this Plan and will result in your being personally responsible for reimbursing us.
3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program (called the "BlueCard Program"), in which we participate, which allows our Covered Persons to have the reciprocal use of participating providers that contract with other Blue Cross and/or Blue Shield Plans. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield participating provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan. In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the BlueCard Program rules as set by the Blue Cross and Blue Shield Association.

When you obtain health care services through BlueCard outside of California, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or

The negotiated price that the on-site Blue Cross and/or Blue Shield ("Host Blue") passes on to us. Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholdings, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Participant liability calculation methods that differ from the usual BlueCard method noted above in paragraph two of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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

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

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:

BC Life & Health Insurance Company
Customer Service
21555 Oxnard Street
Woodland Hills, CA 91367
818-234-2700

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP