4 Ever Life Insurance Company

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Powell Industries, Inc.
GeoBlue Traveler

Supplemental Blanket Travel Plan

Policy Holder: Powell Industries, Inc.
Certificate of Coverage: 4EL-6609-18
Effective Date: July 1, 2018

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

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

SECRETARY

PRESIDENT

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I. Introduction

About This Plan
This Certificate of Coverage is issued by 4 Ever Life Insurance Company ("Insurer") through a policy issued to HTH International Group Insurance Trust.

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

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

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

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

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

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

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

A. BlueCard® Program

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

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

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

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

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

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

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

1. Member Liability Calculation

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

2. Exceptions

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

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

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

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

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

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

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

BENEFIT OVERVIEW MATRIX

Policy Maximums	**Insurer pays up to Per Insured Person**
Trip Period Maximum Benefits	$250,000
Period of Insurance Maximum Benefits	$250,000
Benefits	**Insurer pays**
Professional Services a. Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab	100%
b. Office Visits: including X-rays and lab work billed by the attending physician.	100%
Inpatient Hospital Services	
a. Surgery, X-rays, In-hospital doctor visits	100%
b. In-patient medical emergency	100%
Ambulatory Surgical Center	100%
Ambulance Service (non Medical Evacuation)	100% up to $1,000
Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor)	Limited to Trip Period Maximum or $10,000 whichever is less.
Outside Home Country Outpatient prescription drugs	100% of Covered Expenses
Dental Care required due to an Injury	100% of Covered Expenses up to $200 with maximum per Trip Period
Dental Care for Relief of Pain	100% of Covered Expenses up to $100 per Trip Period
Repatriation Of Remains	Deductible is not applicable. Maximum Benefit up to $25,000.
Medical Evacuation	Deductible is not applicable. Maximum Benefit per Trip Period for all Evacuations up to $250,000.
Bedside Visit	Deductible is not applicable. Maximum Benefit per Trip Period up to $1,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person.

II. Who is eligible for coverage?

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

Who is Eligible to Enroll Under This Plan?

An Eligible Participant:
1. Is 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.

Eligible Dependents
An Eligible Dependent means a person who is the Eligible Participant's:
1. spouse; partner;
2. unmarried natural child, stepchild or legally adopted child who has not yet reached age 26;
3. own or spouse's own unmarried child, of any age, enrolled prior to age 26, 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 26th birthday and annually thereafter;
4. For a person who becomes an Eligible Dependent (as described below) after the date the Eligible Participant's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:
   a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
   b. Adopted Children: An 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;.
5. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

As used above:
1. The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
2. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
3. The term "partner means an Eligible Participant's spouse or domestic partner.
4. The term "domestic partner" means a person of the same or opposite sex who:
   a. is not married or legally separated;
   b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
   c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;
   d. occupies the same residence as the Eligible Participant;
   e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
   f. as entered into a domestic partnership arrangement with the named Insured.
5. The term "domestic partnership arrangement means the Eligible Participant and another person of the same or opposite sex or has any three of the following in common:
   a. joint lease, mortgage or deed;
   b. joint ownership of a vehicle;
   c. joint ownership of a checking account or credit account;
   d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
   e. designation of the domestic partner as a beneficiary of the employee's will;
   f. designation of the domestic partner as holding power of attorney for health care; or
   g. shared household expenses.

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

Additional Requirements for an Insured Person: An Insured Person must meet all of the following requirements:
1. under Age 70.
2. enrolled in a Primary Plan.
3. Eligible Dependents must be traveling with the Eligible Participant.

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

Period of Insurance: Each Eligible Participant's and his/her Eligible Dependent's Period of Insurance starts on the latest of the following:
1. The Policy Effective Date; or
2. 12:00:01 am on the date designated by the Group of which the Eligible Participant is a member.

Trip Coverage Start Date: The Insured Person's coverage under the Policy for a trip during the Period of Insurance starts as stated below:
1. For a scheduled business trip or sojourn to a Foreign Country, when the Insured Person boards a conveyance at the start of the trip.

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

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

How Period of Insurance Coverage Ends

Insured Persons
The Insured Person's coverage ends without notice from the Insurer on the earlier of:
1. the end of the last period for which premium payment has been made to the Insurer;
2. the date the Policy terminates;
3. the date the Maximum Trip Coverage Period Benefit of the Plan has been exhausted;
4. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision.

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

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

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

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

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

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

III. Definitions

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

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

Age means the Insured Person's attained age.

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

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

Coinsurance is the percentage of Covered Expenses the Insured Person is responsible for paying (after the applicable Deductible is satisfied). **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.

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 participating in the Federally Guaranteed Student Loan Program. The student must be currently attending classes, carrying at least 12 units per term.

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

Group Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

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

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

A **Hospital** 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 who is covered under this Plan.

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

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

Investigative Procedures (See Experimental/Investigational).

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

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

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

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

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

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

Out-of-Pocket Maximum is the amount of Coinsurance each Insured Person incurs for Covered Expenses in a Period of Insurance. The Out-of-Pocket **does not** include any amounts in excess of Covered Expenses, the Deductible, any 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 or treatment was received during the 6 months immediately preceding the Insured Person's Trip Coverage Start Date.

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

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

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

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

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

Totally Disabled or Total Disability means:

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

The patient must be under the care of a Physician.

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

U.S. means the United States of America.

IV. How the Plan Works

The Insured Person's Plan pays a portion of his/her Covered Expenses after he/she meets his/her Deductible for each Period of Insurance. 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 $0 per Insured Person per Period of Insurance. This Deductible is the amount of Covered Expenses the Insured Participant and other Insured Persons must pay for **any** Covered Services incurred for services received.

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

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

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

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

For all other Covered Expenses

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

Period of Insurance Maximum Benefits
The combined total of all medical benefits paid to the Insured Person is limited to a maximum of $250,000 during each Insured Person's Period of Insurance, so long as the Insured Participant or the Insured Dependent remains insured under this Plan.

Trip Coverage Period Maximum Benefits
The combined total of all medical benefits paid to the Insured Person is limited to a maximum of $250,000 during each Trip Coverage Period for each Insured Person, so long as the Insured Participant or the Insured Dependent remains insured under this Plan and so long as the cumulative amount of paid benefits for all Trip Coverage Periods within the Period of Insurance does not exceed the Period of Insurance Maximum.

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

V. Benefits: What the Plan Pays

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

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

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

Services and Supplies Provided by a Hospital
For any eligible condition other than for Mental, Emotional or Functional Nervous Conditions or Disorders, Alcoholism or Drug Abuse, the Insurer will pay indicated benefits on Covered Expenses for:
1. Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
2. Outpatient services and supplies including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.

Payment of Inpatient Covered Expenses are subject to these conditions:
1. Services must be those which are regularly provided and billed by the Hospital.
2. Services are provided only for the number of days required to treat the Insured Person's Illness or Injury

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

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

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

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

Dental Care for an Accidental Injury
Benefits are payable for dental care for an Accidental Injury to natural teeth that occurs while the Insured Person is covered under this Plan, subject to the following:
1. services must be received during the six months following the date of Injury;
2. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury; and
3. damage to natural teeth due to chewing or biting is not considered an Accidental Injury under this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Excluded Services

The Plan does not provide any benefits for:

1. 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) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (b) An Insured Person participating in the **military service** of any country; (c) An Insured Person participating in an **insurrection, rebellion, or riot**; (d) 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;** (e) 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. 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.
13. Inpatient or outpatient services of a **private duty nurse.**
14. 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.
15. 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.
16. Treatment of **Mental, Emotional or Functional Nervous Conditions or Disorders.**
17. Treatment of **Drug, alcohol, or other substance addiction or abuse**.
18. **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.
19. Dental and orthodontic services for Temporomandibular Joint Dysfunction (**TMJ**).
20. **Orthodontic Services,** braces and other orthodontic appliances except as specifically stated under Orthodontic Dental Care.
21. **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.
22. **Hearing aids.**
23. Routine **hearing tests.**
24. **Optometric services,** eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.
25. An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
26. Outpatient **speech therapy**.
27. Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.
28. 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.
29. **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.
30. 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**.
31. Treatment of **sexual dysfunction** or inadequacy.
32. 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
33. All **contraceptive** services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures.
34. **Cryopreservation** of sperm or eggs.

35. **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.
36. 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.
37. **Routine physical exams** or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority.
38. Charges by a provider for **telephone consultations.**
39. 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.).
40. **Educational services** except as specifically provided or arranged by the Insurer.
41. **Nutritional counseling** or food supplements.
42. **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.
43. **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.
44. All **infusion therapy, radiation therapy and hemodialysis treatment** together with any associated supplies, Drugs or professional services are excluded.
45. **Growth Hormone Treatment.**
46. 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.
47. **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.
48. Charges for the services of a **standby Physician.**
49. Charges for **animal to human organ transplants.**
50. 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.
51. Claims arising from loss due to riding in any **aircraft** except one licensed for the transportation of passengers.
52. 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.
53. Treatment for or arising from **sexually transmittable diseases**. (This exclusion does not apply to HIV, AIDS, ARC or any derivative or variation.)
54. 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 Insured Person's Home Country without the prior approval of the Administrator.
55. Treatment of **Congenital Conditions**.

VII. Prescription Drug Benefits

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

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

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

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

The Prescription must not exceed a 30-day supply.

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

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

VIII. General Provisions

Third Party Liability

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

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

Benefits for Medicare Eligible Insured Persons

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

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

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

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

Alternate Cost Containment Provision

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

Terms of the Insured Participant's Plan

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

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

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

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

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 has been received, the Insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the Insured Person the reasons the Insurer may have for denying such claim or any portion thereof.

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

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

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

Assignment of Claim Payments: The Insurer will recognize any assignment made under the Plan, if:
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 has the right to examine any records of the Group, any person, company or organization which may effect the Premiums and benefits of the Plan.

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

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:

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

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 Person or the Group because the Insured Person'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.

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois 60181
(800) 621-9215
Administrative Office: c/o Worldwide Insurance Services, LLC, 933 First Avenue, King of Prussia, PA 19406

Endorsement to Policy/Certificate

State of Texas

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, with respect to Covered Persons residing in the state of Texas, as follows:

1. The following Complaint Notice is added to the certificate:

IMPORTANT NOTICE	**AVISO IMPORTANTE**
To obtain information or to make a complaint:	Para obtener información o para presentar una queja:
You may call 4 Ever Life Insurance Company's toll-free telephone number for information or to make a complaint at: 1-800-621-9215	Usted puede llamar al número de teléfono gratuito de 4 Ever Life Insurance Company's para obtener información o para presentar una queja al: 1-800-621-9215
You may also write to 4 Ever Life Insurance Company at: 4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181	Usted tambien puede escribir a 4 Ever Life Insurance Company: 4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, Illinois 60181
You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at: 1-800-252-3439	Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al: 1-800-252-3439
You may write the Texas Department of Insurance: P.O. Box 149104 Austin, TX 78714-9104 FAX (512) 490-1007 Web: www.tdi.texas.gov	Usted puede escribir al Departamento de Seguros de Texas a: P.O. Box 149104 Austin, TX 78714-9104 FAX (512) 490-1007 Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov	E-mail: ConsumerProtection@tdi.texas.gov
PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.	**DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.
ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.	**ADJUNTE ESTE AVISO A SU POLIZA:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

2. The **Change in Premium** provision found on page 2 of the Policy is deleted and amended as follows:

   Change in Premium: The Insurer may change the premiums due on or after the first Policy Anniversary Date but not more often than once in any 12 month period The Insurer shall give written notice of such change at least 60 days in advance. The premium rates applicable to the Policy are on file with the Policyholder, the Administrator and the Insurer. The Insurer further reserves the right to re-determine the premium rate on any date on which the Policy is amended.

3. The definition of "**Emergency Hospitalization and Emergency Medical Care**", is deleted and replaced with the following:

   Emergency Medical Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
   1. placing the patient's health in serious jeopardy;
   2. serious impairment to bodily functions; or
   3. serious dysfunction of any bodily organ or part.

4. The definition of **Pre-Existing Condition**", is deleted in its entirety and replaced with the following:

   Pre-existing Condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured Person's Trip Coverage Start Date; or (2) condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured Person's Coverage Start Date.

5. The Time Payment of Claims provision found under Section VIII, General Provisions, is amended to provide that benefits payable under the Policy, other than benefits for loss of time, shall be paid not later than 60 days after receipt of written proof of loss.

6. The Payment of Claims provision found under Section VIII, General Provisions, is amended to include the following provisions:

   Payment to the Texas Department of Human Services. All benefits paid on behalf of the child or children under the Policy must be paid to the Texas Department of Human Services whenever: (1) the Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31, or Chapter 32, i.e. financial and medical assistance service programs administered pursuant to the Human Resources Code; and (2) the parent who is covered by the Policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support. The Insurer must receive at its home office written notice affixed to the insurance claim when the claim is first submitted stating that all benefits paid must be paid directly to the Texas Department of Human Services.

   Benefits will not be reduced or denied because such benefits are covered by the Medical Assistance Act of 1967, as amended. Benefits will be paid to the Texas Department of Human Resources for the actual cost of medical expenses it pays through medical assistance for a person insured by the Policy, if the Covered Person would otherwise be entitled to payment of benefits for such medical expenses. Benefits so paid, in no event, will exceed benefits otherwise payable under the Policy. Any benefits payable for expenses not paid by such Department will be paid as provided in the Policy.

   Payment to Possessory or Managing Conservator of Dependent Child. For a minor child who otherwise qualifies as a Dependent of the Eligible Participant, benefits may be paid on behalf of the child to a person who is not the Eligible Participant if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

   To be entitled to receive benefits, a possessory or managing conservator of a child must submit to the Insurer with the claim form, written notice that such person is the possessory or 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 the possessory or 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 Eligible Participant where the Eligible Participant had paid any portion of a medical bill that would be covered under the terms of the Policy.

7. The Extension of Benefits provision found under Section II, Who Is Eligible For Coverage?, is amended to include the following language:

   If the Insurer terminates the Policy, coverage will be extended for an Insured 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 Insured 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 Insured Person's insurance terminates.

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

8. The definition of Eligible Dependent is deleted in its entirety and replaced with the following:

   Eligible Dependents
   An Eligible Dependent means a person who is the Eligible Participant's:
   1. spouse; partner;
   2. unmarried natural child, stepchild or legally adopted child who has not yet reached age 26;
   3. own or spouse's own unmarried child, of any age, enrolled prior to age 26, 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 26th birthday and annually thereafter;
   4. For a person who becomes an Eligible Dependent (as described below) after the date the Eligible Participant's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:
      a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth. Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature 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, an Insured Participant must enroll the adopted child within 31 days either from the date of placement or the final decree of adoption.
      c. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is spouse or minor child, coverage will be automatic for the first 31 days following the date which the court order is issued. To continue coverage beyond 31 days, and Insured Participant must enroll the Eligible Dependent within that 31 day period
      d. Party in a Suit for Adoption of Child**:** A child of an Insured Partipicant who is a party to a suit for which adoption of the child is sought, is covered on the same basis as described above for a newborn. Coverage starts on the date the Insured Participant becomes a party to a suit to adopt the child provided the Insured Participant's coverage is then in force. Coverage terminates if the Insured Participant loses the suit for adoption of the child;
   5. a grandchild of the Insured Participant who is less than age 25 and is a dependent of the Insured Participant for federal income tax purposes at the time application for coverage is made. Coverage for a grandchild may not be terminated solely because he or she is no longer a dependent of the Insured Participant for federal tax purposes;
   6. a child who is adopted by the Eligible Participant or placed for adoption with the Eligible Participant prior to age 25 (a child for which the Eligible Participant is a party in a suit in which the adoption of the child is sought shall be deemed an adopted child);
   7. a child for which the Eligible Participant is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court of this state, and any other person dependent upon the Eligible Participant;
   8. a student who is 25 years of age or older and enrolled in an educational institution for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date. For purposes of this section, determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child is enrolled;
   9. niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

As used above:

1. The term “primary care” means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
2. The term “spouse” means the Eligible Participant’s spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy is issued.
3. The term “partner means an Eligible Participant’s spouse or domestic partner.
4. The term “domestic partner” means a person of the same or opposite sex who:
   a. is not married or legally separated;
   b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
   c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;
   d. occupies the same residence as the Eligible Participant;
   e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
   f. as entered into a domestic partnership arrangement with the named Insured.
5. The term “domestic partnership arrangement means the Eligible Participant and another person of the same or opposite sex or has any three of the following in common:
   a. joint lease, mortgage or deed;
   b. joint ownership of a vehicle;
   c. joint ownership of a checking account or credit account;
   d. designation of the domestic partner as a beneficiary for the Eligible Participant’s life insurance or retirement benefits;
   e. designation of the domestic partner as a beneficiary of the employee’s will;
   f. designation of the domestic partner as holding power of attorney for health care; or
   g. shared household expenses.

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

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

SECRETARY

PRESIDENT